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Touching the Unseen: An Investigation of Hypnotic Conflict

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Resolving the conflict between hypnotic suggestion and conflicting reality information is fundamental to understanding hypnotic responding. Twenty-nine high and 25 low hypnotisable subjects were administered a suggestion for a negative visual hallucination of an object, and were subsequently required to touch the position where the "unseen" object was located. Nine high hypnotisable subjects initially passed the suggestion, and six (67%) of these subjects subsequently saw the object when they touched it. Three (33%) subjects maintained hypnotic blindness of the object by employing behavioural or cognitive strategies that reduced awareness of the object during the conflict manipulation. These findings are discussed in terms of the active problem-solving strategies employed by hypnotic subjects to manage hypnotic conflict.

Hypnosis has often been conceptualised as the resolution of conflict between the hypnotic suggestion and reality information (McConkey, 1983a). For example, maintaining belief in a suggestion for a negative visual hallucination (i.e., hypnotic blindness) requires the subject to reduce the conflict between available visual information and the suggestion to not see. Previous work indicates that the extent to which subjects can achieve this difficult hypnotic task is dependent on the ability to employ cognitive strategies that minimise the conflict (Bryant & McConkey, 1989). Theorists have typically argued that hypnotic subjects resolve the conflict between suggestion and reality by either being absorbed in the hypnotic experience (Tellegen & Atkinson, 1974) or

because the hypnotic suggestion directs subjects to ignore conflicting information (Orne & Hammer, 1974).

A number of paradigms have been used to investigate resolution of hypnotic conflict. These include communications from the hypnotist that conflict with the hypnotic suggestion (McConkey, 1983b; Zamansky, 1977), contradicting subject's preconceptions about hypnosis and hypnotic responding (Sheehan, 1980), and trance logic paradigms (e.g., the subject hallucinates a person and simultaneously views the person) (McConkey, Bryant, Bibb, & Kihlstrom, 1991). Each of these approaches involves the hypnotist providing information that directly conflicts with the suggested effect. Overall, these studies indicate that subjects resolve the potential conflict by responding to the perceived demands of the hypnotic communication (McConkey, 1983a).

A problem with existing research on hypnotic conflict is that the paradigms involve salient changes in the hypnotist's communication. It is likely that these changes in communication alter demand characteristics and result in compliance to different perceived demands (Spanos, 1986). This pilot study was intended to investigate subjects' conflict resolution when the suggested effect was challenged by an action that did not involve salient demand characteristics. Specifically, we administered a suggestion for a negative visual hallucination of a box, and then requested subjects to touch the spot where the "unseen" box was located. We predicted that subjects would be unable to maintain their belief in the suggested blindness after touching the box because touching the box would cause excessive conflict.

METHOD

Participants

Twenty-nine high hypnotisable individuals of mean age 20.14 years (SD = 5.66) and 25 low hypnotisable individuals of mean age 19.36 years (SD = 2.86), who were first-year psychology students at the University of New South Wales, participated in this experiment in return for research credit. Subjects were selected on the basis of their extreme scores on a 10-item tailored version of the Harvard Group Scale of Hypnotic Susceptibility: Form A (HGSHS: A; Shor & Orne, 1962), and a 10-item tailored version of the Stanford Hypnotic Susceptibility Scale: Form C (SHSS: C; Weitzenhoffer & Hilgard, 1962), which was administered during the hypnosis session for this experiment. Low hypnotisable subjects scored in the range 0 − 2 (M = 0.76, SD = 0.72) on the HGSHS: A and in the range 0 − 3 (M = 1.84, SD = 1.18)

on the SHSS: C. High hypnotisable subjects scored in the range 8 − 10 (*M* = 8.43, *SD* = 0.59) on the HGSHS: A and in the range 8 − 10 (*M* = 8.63, *SD* = 0.74) on the SHSS: C.

Apparatus

The stimuli for the negative visual hallucination item were three boxes of identical dimensions, each of a different colour (green, blue and yellow). The boxes were placed on a small rolling table that could be moved close to the subject for the stimulus presentation. During the remainder of the hypnosis session the table and boxes were concealed from view.

Procedure

The experimenter welcomed subjects and gave them a brief overview of the experiment. Subjects were then asked to read and sign an informed consent form. The experimenter then administered the standard SHSS: C induction procedure, and tested subjects on the 10 items of the tailored SHSS: C. These items included hand lowering, moving hands apart, mosquito hallucination, taste hallucination, arm rigidity, dream, age regression, arm immobilisation, negative visual hallucination, and post-hypnotic amnesia.

   During the suggestion for a negative visual hallucination, subjects were instructed that they would see two boxes in front of them. Three boxes, each of a different colour, were then placed on a small table in front of subjects. The criterion for a positive response to the negative visual hallucination item was a report that they could see only two of the three boxes. Subjects who passed the negative visual hallucination item were asked to rate their confidence that the table held only two boxes (1 = not at all confident, 10 = extremely confident). The experimenter asked subjects to describe the colours of the boxes, then instructed subjects to place their hand on a particular part of the table depending on their response. Specifically, subjects were instructed to place their hand on the position where the box that they did not report seeing was positioned. For example, subjects who did not report the colour of the central box were instructed to place their hand on the table between the two boxes. The experimenter then asked subjects to provide a second rating of their confidence that there were just two boxes, cancelled the hypnotic suggestion, and administered the SHSS: C post-hypnotic amnesia item, de-induction and recall tests.

   For subjects who passed the negative visual hallucination item, the

experimenter conducted a post-experimental inquiry that examined their experiential response to the suggestion. The experimenter asked subjects to report on their thoughts when they first opened their eyes to look at the boxes, and then asked subjects to describe their thoughts when they placed their hand on the table.

RESULTS

Behavioural Data

Nine (31%) high hypnotisable and no low hypnotisable subjects passed the negative visual hallucination item. Accordingly, subsequent analyses focused on the response of these 9 high hypnotisable subjects. Subjects' belief in the negative visual hallucination was significantly lower when they were exposed to tactile information that contradicted the hypnotic suggestion ($M = 3.22$, $SD = 2.95$) compared to when the conflict involved only visual information ($M = 7.78$, $SD = 2.22$, $t(8) = 3.86$, $p < .01$). Six (67%) subjects decreased their belief rating when they were asked to touch the "unseen" box. Interestingly, three (33%) subjects maintained their initial belief in the hallucination after they were instructed to touch the "unseen" box. Two of these subjects maintained their belief in the suggestion by avoiding the conflicting tactile information by touching a part of the table away from the "unseen" box.

Experiential Data

The subjects who did and did not maintain their belief in the suggestion after the conflict manipulation displayed distinct experiential responses in the post-experimental inquiry. Those who did not maintain the suggested hallucination reported that they had initially attained the suggested hallucination by employing strategies that allowed them to ignore the critical box. Representing this strategy, one subject reported: "I knew there was something on the periphery but I didn't allow myself to focus on it . . . but when I touched the box I had to be aware of what was there." In contrast, the subjects who maintained their belief in the actively employed strategies that minimised their awareness of the conflicting information. The subject who touched the "unseen" box but maintained her belief reported that "I felt something there but somewhere inside of me insisted that there were only two boxes, and I so I believed that there were only two boxes." Similarly, one of the subjects who avoided the tactile conflict stated that "I felt that if I put my hand there it

would show there was a box there, and so something just led me to put my hand somewhere else . . . but it was not intentional."

DISCUSSION

The finding that 6 out of the 9 subjects who passed the negative visual hallucination did not maintain the suggestion when they placed their hand on the "unseen" box is consistent with the notion that maintenance of a hypnotic suggestion is difficult in the face of salient conflict. These subjects' post-experimental comments indicated that touching the critical box during the suggestion interfered with their initial strategies that involved ignoring awareness of the box. It appears that the tactile information directed subjects' attention directly to the information that conflicted with the suggestion. These comments support the view that hypnotic responding requires successful neglect of conflicting information (Spanos, 1986).

In contrast, one-third of the subjects maintained their belief in the suggestion despite being directed to touch the box. The difficulty of managing the conflict of touching a box that was subjectively not present led two subjects to respond to the experimental instruction by avoiding touching the "unseen" box. That is, these subjects modified their interpretation of the experimental instruction in order to minimise the conflict between the suggestion and reality information. This response highlights the strategies that subjects engage in to satisfy the hypnotic communication. This finding is consistent with previous reports of hypnotic subjects engaging in problem-solving exercises to resolve potential conflict during negative visual hallucinations (Bryant & McConkey, 1989; 1990). Similarly, the subject who touched the "unseen" box and still maintained her belief in the suggestion displayed a response that allowed her to cognitively ignore the importance of the tactile information. This response was phenomenologically similar to trance logic because she was able to tolerate the incongruity between touching a box that she was able to convince herself was not visible (McConkey et al., 1991). Collectively, the subjects who maintained their belief in the suggestion reflect the commitment of hypnotic subjects to the hypnotic communication, and the extent to which they modify interpretations of reality in a way that reduces conflict.

We recognise that inferences from this study are limited by the possibility that demand characteristics may have influenced subjects' responses. Although the procedure of having subjects touch the "unseen" box was intended to

maximise conflict in a way that did not communicate salient experimental demands, we did not index perceived demand characteristics. The use of the real-simulating (Orne, 1959) or non-experimental (Orne, 1969) paradigms would have allowed an index of the extent to which subjects perceived the experimenter's expectations about their responses to touching the box. Further, investigating more closely the cognitive responses used to manage the hypnotic conflict (e.g., the Experiential Analysis Technique, Sheehan & McConkey, 1982) would clarify the specific strategies that mediate successful conflict resolution.

Resolving the conflict between hypnotic suggestion and incompatible information is fundamental to understanding hypnotic phenomena. Hypnotic subjects employ a combination of behavioural and cognitive strategies to minimise awareness of information that conflicts with the hypnotic suggestion. These strategies highlight the active problem-solving role that subjects adopt during hypnosis to meet the requirements of the hypnotic communication. Future research needs to develop paradigms that can introduce conflict into the hypnotic situation without salient demand characteristics and to identify the motivational, cognitive, and affective factors that interact to resolve hypnotic conflict.

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Repression: R.I.P.

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The concept of repression has had a central place in theorising about the unconscious, the nature of memory, and the ways in which hypnosis may work. This Freudian mechanism has more recently come under attack in many quarters, together with the more general understanding of the unconscious. Reappraisal of its place became urgent as a result of the upsurge of attention to recovered memories in therapy, especially in hypnosis, followed by the research that cast serious doubts on the explanatory power of repression as a hypothesised mechanism. Dissociation has often been misleadingly treated as a near synonym for repression, yet for those who practise hypnosis, a clear distinction is needed. The archaic views of the unconscious, memory processes, and childhood sexuality derived from Freud deserve a quiet resting place.

Repression as a concept has been a central plank in Freudian theory. It occupies a strategic place in the theory of the unconscious, where it serves the function of maintaining material out of consciousness. Although Freud's theory of personality is often represented as comparable to an iceberg, with the unconscious below the waterline, and repression at the waterline, this does not really do justice to the dynamic role attributed to repression. It is more than a waterline. The model actually has more coherence if we recall that Freud was theorising at the time when hydraulic power was making its social impact. A hydraulic pump involves a build up of pressure that is associated with energy, and requires a pressure valve to ensure that the energy is released safely and productively. Reflect on this definition with Freud in mind: "Valves play an important role in hydraulic systems. They regulate the oil pressure or oil

flow and open or close the lines. A safety valve is provided in most hydraulic systems and prevents the build up of excessive pressure. Different valves serve to maintain constant oil pressure in each part of the system" (Dick, 1995). The parallels with the energy system of libido needing the control of the defence mechanisms, especially repression, are close enough to make the model attractive to those who lived through the industrial age.

To those who believe Freudian theory is the essence of personality theory and immutable, it might seem heresy to suggest that repression no longer serves a useful function. It might also seem inappropriate to challenge a concept that has been around for a century — unless there are good grounds for doing so. One reason for a challenge might be the pragmatic argument that the concept of repression is at the heart of the repressed memories controversy, which is causing pain to patients, confusion for professionals, and creating especial problems for the practitioners of hypnosis as the chances of litigation increase. A second reason might be that Freud not only favoured the concept of repression over dissociation in his early discussions with Janet, but the corollary of this was that he rejected hypnosis as a useful vehicle for therapy. It is difficult to see why hypnotherapists would want to embrace repression, but it has been utilised very widely as an explanatory concept. A third reason for challenging the concept comes from verdicts from science, saying "repression folklore … is partly refuted, partly untested, and partly untestable" (Loftus, in Myers, 1999, p. 39), and in a similar vein, Holmes notes "the concept of repression has not been validated with experimental research and its use may be hazardous to the accurate interpretation of clinical behavior" (Holmes, 1990).

CONFUSION

A look at the current literature indicates the complexity of what we are being asked to believe about repression. In the difficult area of memories, there is an assortment of terminologies, sometimes carefully chosen to embrace a theoretical stance, and at others used indiscriminately. Sometimes even our hypnosis colleagues use them in ways that add to the confusion by treating various different terms as if they were synonymous.

A quick look at the current literature makes it clear that practitioners are still using terms such as repression and "repressed memories" (McDonald, 1995). Referring to the same phenomenon, others choose the term "false memories" (Perry, 2000). Other variants include "retrieved memories,"

"reported memories" (APA, 1995), "suggested memories" (Sheehan, 1997), "recovered memories" (Hopper, 1999; Sheehan, 1997), and "dissociated memories" (Spanos, 1996). There are various assumptions behind these terms that raise questions about the suitability of repression as an explanatory concept.

OPINIONS

To maintain that repression is the correct term to use is to ally oneself solidly with Freud at a time when the validity of his theories is being even more seriously questioned than when he first introduced them. We can thank an Australian, Malcolm Macmillan (1999), for the most substantial and comprehensive deconstruction of Freud's ideas yet published. In his book *Freud Evaluated*, Macmillan deals with repression in many places and comes in various ways to a very pessimistic view of the concept. After lengthy exploration he summarises his position saying, "Repression is an uncharacterised theoretical term that has been substituted for the relation Freud wanted to explain. It tells us only what the repression is supposed to do, not what it is, and it has no potential for referring to real processes" (Macmillan, 1999, pp. 160–161).

McDonald, in a book called *Repressed Memories*, moves away from Freud to say "psychologists have developed broad, diverse definitions of repression," which may well mean the term has lost its clear meaning, and she goes on to say, "It is often related to *dissociation*, in which part of one's consciousness breaks away and functions as a separate unit" (McDonald, 1995). Putting the two terms together as near synonyms is not helpful. They are distinct in meaning and carry quite different implications for theory and practice.

Cam Perry, in his manuscript published last year in this journal, also runs the two closely together, while distancing himself from Freud's original concept. "I believe that something like repression is possible. I suspect, though, that it may differ from the repression that Freud talked about a century ago, and the *déségration* (translated into English as dissociation) that his French contemporary, Pierre Janet, emphasised. Although there are some subtle differences in the theorising of these two investigators, they are, to all intents and purposes, discussing a similar mechanism. Indeed, many people these days use the terms 'repression' and 'dissociation' interchangeably" (Perry, 2000, p. 11). Sadly they do, but it is time we stopped equating the two theorists who so radically disagreed with each other, and time to look to concepts more suited to the 21st century.

Peter Sheehan, also in this journal, discusses what we know about *recovered* memories. With that focus, his concern is not particularly with the concept of repression, and he runs the two terms together without distinction. For example: "Repression and dissociation are key processes for some theories" (Sheehan, 1997, p. 21; cf p. 22), but then goes on to question the validity of repression.

We might expect to look for clarity from the American Psychological Association (APA), but in its current web-based advice to the public on reported memories of childhood abuse, it backs both terms. "Some … clinicians believe that dissociation is a likely explanation for memory that was forgotten or later recalled. Dissociation means that a memory is not actually lost, but is for some time unavailable for retrieval" (APA, 1995). The statement then invokes the terminology of repression saying: "The issue of repressed or suggested memories has been overreported and sensationalised by the media" (APA, 1995).

Eugene Bliss (1986), writing about hypnosis and dissociative disorders, similarly has little time for repression, arguing that Freud favoured that concept over against dissociation as a mechanism, thereby profoundly influencing the way we think about the unconscious, and minimising the importance of a mechanism that seems much more consistent with hypnotic work.

He calls repression a "euphemism for 'forgetting' and a 'semantic evasion'" and "it contained no explanatory power." He prefers to go back to Breuer's preference for "hypnoid states," or "self-hypnosis," which look a lot like Janet's dissociation, and argues that Freud's dominance in the field is unfortunate. Bliss quotes Freud as saying "the theory of repression became the foundation stone of our understanding of the neuroses."

Nick Spanos, following a similarly critical path, notes that "Freud's ideas competed with, and by the early 1920s largely displaced, notions concerning dissociation" (Spanos, 1996). For those who studied their psychology a long while ago, it is worth quoting the current introductory textbook opinion from David Myers: "Sigmund Freud's entire psychoanalytic theory rests on his assumption that the human mind often *represses* painful experiences … Under Freud's influence, repression has been used to explain hypnotic phenomena and many psychological disorders. It is also one of popular psychology's most widely accepted concepts . . . Actually, contend many of today's researchers, repression, if it ever occurs is a rare mental response to terrible trauma" (Myers, 1999).

Gradually, we are getting to a better place. With the rehabilitation of hypnosis, research on altered states of consciousness, and more attention to the phenomena of dissociation, including PTSD, we can afford to recognise the underlying assumptions that differ between repression and dissociation, and which lead to alternative ways of proceeding therapeutically.

DISTINCTIONS

Two sources are enough to highlight the move away from repression. A solid web-site of research on recovered memories of sexual abuse sponsored by Jim Hopper notes that terms like repression and dissociation are merely explanatory psychological constructs and "when it comes to empirical evidence of traumatic and recovered memories, dissociation is more descriptive of more empirical evidence than is repression" (Hopper, 1999, p. 5).

Included in his summary of research evidence is the work of Elizabeth Loftus, known for her criticisms of repressed memories and John Briere, among many others. We recall hearing both of them debate the evidence on recovered memories at the APA Conference of 1993 in Toronto, when it became clear that they were polarised in part because one is a researcher and the other a clinician, but also because it appeared that Loftus was attacking repression, while Briere was defending dissociation. It was a remarkable and heated debate, but quite unable to achieve a meeting of minds.

Hopper's review favours dissociation as a far more satisfactory concept than repression, without claiming it provides a totally satisfactory framework, noting particularly that Brewin and Andrews say that: "Use of the term *repression* has led to confusion because it can be defined in quite different ways, and dissociation, although often co-existent with traumatic anmesia is concerned with alterations in consciousness rather than specifically with forgetting" (Brewin & Andrews, 1998; 2000).

They argue for replacing both terms "with an account based on cognitive science." This also appears to be the view of John Schumaker (1995), another Australian with an interest in hypnotic phenomena. In *The Corruption of Reality* he argues for moving beyond Hilgard's neo-dissociation theory through a complex model proposed by Charles Tart. Nonetheless he still favours dissociation in many ways, and distinguishes it very clearly from repression. His analysis is helpful in showing why it is important to distinguish the terms, and why we should abandon repression altogether:

Psychoanalytic theory came to rest on the now familiar assertion that psychic integrity depends upon the maintenance of a line of defense against unacceptable thought, desires and instinctual demands. This caused the thinking of Freud and his early associates to gravitate toward the Cartesian dualism of conscious/unconscious. In this "vertical" model of the mind, Freud postulated the existence of a repression barrier that served to prevent *unacceptable* information from reaching consciousness . . . Dissociation was largely abandoned as the mechanism by which threatening material was effectively isolated from mainstream consciousness. Instead, Freud developed the concept of repression . . . dissociation disappeared as the method by which psychoanalytic theorists explained the defensive control and regulation of cognitions . . . By contrast, dissociation theory involves a "horizontal" model of mind that does not equate consciousness with awareness . . . Herein lies the greatest strength of dissociation theory. Its fundamental premise of multiple parallel channels of information processing opens up the possibility that the human being is capable *simultaneously* of being both "in touch" and "out of touch" with reality. (Schumaker, 1995, pp. 22-24)

CONTRASTS

Freud's hydraulic 19th-century formulation of repression required a clear distinction between conscious and unconscious — a dilemma many have noted as a major flaw, and admitted by Freud in his latter days (Schumaker, 1995, p. 42). It requires us to understand human nature as being composed of a vast hidden reservoir of unacceptable impulses, contained only with difficulty by the strength of the repression barrier. It involves a determinist and pessimistic view of motivation, reflective more of Freud himself and his patients than contemporary reality.

To follow David Myers again: "It is time to abandon Freud's view of the unconscious . . . Many researchers think of the unconscious not as seething passions and repressive censoring, but as cooler information processing that occurs without our awareness" (Myers, 1999, p. 40).

Dissociation, on the other hand, while it comes from the same period originally, has been an important element in hypnotic theory since Hilgard's (1977) neo-dissociation theory. Rather than drawing on the hydraulic pump metaphor, it fits more readily with systems thinking, which attends more to interpersonal forces than intrapsychic tensions.

The advent of family therapy moved us away from the Freudian paradigm, introducing us to a completely different epistemology of understanding and

conceptualising human behaviour and interaction. This paradigm shift is credited to Gregory Bateson, an anthropologist and ethnologist who, in 1972, began to apply cybernetic principles to humans — a systems ability for self–regulation applying information about past performance to produce equilibrium in the present (Goldenberg & Goldenberg, 1996, p. 8). The feedback mechanisms of Freudian belief were now applied to human communication, introducing the theory that schizophrenia was a relational phenomenon rather than an intrapsychic disorder, and that mental functioning operates on positive (amplifying) and negative (homeostatic) feedback.

Unfolding models of systems approaches to treating individuals and families have resulted in clients being encouraged to think differently about their presenting problems. Narrative theory invites people to "externalise" their problem-saturated issue and re-author a story alternative to the one that society or family has placed on them. Similarly, solution-focused therapy produces an almost audible "clunk" when the client is asked, "What needs to happen for this [problem] to be solved?"

Virginia Satir's (1991) concept of a parts party invited a person to describe three people he/she admired and three who were detested. During the session the person would come to appreciate his/her personal strengths, but also to access the parts the person disliked in the "detested person." Ultimately these facets of the person are brought to the surface where they are acknowledged, accepted and integrated into the present memory of the person. Satir did not explain this process in discussing it, but it is clear that the mechanism employed is one of dissociation, and there is no need to invoke the unconscious.

The computer also provides us with many analogies, especially since we now have PCs with the parallel processing of the Windows environment, that enables us to work with several programs at the same time. Files can be hidden; they can become corrupted, and hard to access. A file can be retrieved, changed and then stored again under the same name but with altered content. Dissociation, or splitting, can be represented by the use of passwords that allow access to one area of storage but not to another. All of these parallels would suggest dissociation is an entirely normal mechanism and not contingent on severe trauma or morally reprehensible thoughts. None of the similarities with the computer fit well with repression, since there are multiple means of access to the vast store of cognitive information, and no hint of one great barrier preventing access to the "seething passions." Whereas repression is a concept designed to explain pathology, dissociation helps us to understand complexity in normal cognitive processes. While

we shall never develop a full understanding of the complexity of mental processes, the current state of knowledge indicates that it is time to move on from the confines of the Freudian concept of repression, and give it a decent burial. R. I. P.

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Hypnosis and Simple Phobia

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This case study describes the use of hypnosis in the case of a client experiencing a specific phobia, situational type, for driving and being a passenger of a motor vehicle. While hypnosis was effective in facilitating desensitisation, client gains increased with the introduction of elements of imaginative involvement and a close examination of "driving music."

PROBLEM ISSUE

The client (Maureen) was referred via a professional colleague who had conducted an earlier assessment in the context of a personal injury insurance claim. The insurer had accepted liability and offered to fund some eight sessions of treatment for a driving phobia. This phobia was indicated to be fairly severe, being of over 12 months duration and with the client experiencing great anxiety and fear when driving — which she was obliged to do for work and study commitments. She was also fearful of being a passenger in a motor vehicle and of being a pedestrian in the proximity of heavy traffic conditions.

ASSESSMENT

Although broadly aware of the problem situation from my colleague's previous assessment, I conducted a full assessment within the initial session.

Maureen described being involved in a motor vehicle accident while travelling along a motorway towards a capital city early one morning in December 1998, to attend her part-time work as an assistant nurse at a large hospital. She was the sole occupant of the car. She claimed that the collision was of a concertina type, with a truck colliding into the vehicle behind her

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and propelling it into the rear of her own car. She noted that this had occurred in dense, slowly moving traffic. She told me that she had not received any knock or injury to the head, nor did she lose consciousness in this incident — and that the car had sustained minor damage to the car boot and petrol tank.

Maureen received some muscular damage to the right shoulder and neck, but this substantially improved within four to six weeks. However, from the time of collision she described fearfulness of, and an aversion to, driving situations. She noted that this fearfulness was restricted to driving circumstances and that increased anxiety was not triggered by any other situation. She described the fear at this time as being qualitatively different from and more severe than she had experienced after two motor vehicle accidents that had occurred 10 and 25 years previously, although Maureen noted that both previous incidents were more severe.

She identified that the extent and nature of her driving-related fears had essentially remained unaltered since the collision. She identified fear in regard to driving, being a passenger, and being a pedestrian — experienced to varying degrees on the basis of traffic and associated conditions. These fears were marked and persistent and were experienced on each and every occasion. On a SUDS (subjective unit of distress) score from $0 - 10$, she rated driving and being a passenger in "busy" traffic as both being at 9. Maureen did not want to cease driving as a result of these fears, as she was determined to "not give up" and knew that she would have to drive in order to complete her nursing studies and attend work.

However, she exhibited severe avoidance of driving, either by avoiding doing things or by arranging for alternative drivers (her daughter was enlisted to bring her to initial appointments). When circumstances dictated that she had to drive, she planned and otherwise arranged to travel by circuitous routes to avoid heavy traffic conditions. This avoidance of traffic has necessitated her leaving her previous nursing position to work in a local hospital. Her determination to complete studies had given rise to a situation in which, to avoid heavy traffic, she left home at 6.30 a.m. or earlier to attend a 1 p.m. lecture. This demonstrated the degree of avoidance engaged, the level of disruption caused by the phobic condition, and Maureen's determination to not allow this fear to prevent her from reaching her goals.

Unfortunately, when driving she often happened upon changed traffic conditions, sometimes resulting in considerable distress and her being disconsolate and tearful while driving. When experiencing this fear,

physiologically she described her heart beating faster, a tightening of her chest, having difficulty breathing and feeling shaky.

Cognitively, she noted particular fears for vehicles behind her, that she anticipated would or might collide into her — thus she was over-vigilant with car mirrors and highly fearful of close distances between following vehicles. This caused difficulty as a passenger, as she was often compelled to offer her views on the driving situation and generally share her fears within the car, describing herself as being a "passenger from hell."

Maureen had found it very difficult to find any coping mechanisms to ameliorate this situation, although she had endeavoured to use positive self-talk.

HISTORY

Maureen was a 47-year-old married woman living in a rural setting with her postal officer husband. She had two adult daughters, with children of their own, living nearby. She had spent most of her working life in the nursing field, either as an assistant nurse within different hospitals or as a laboratory assistant. She had commenced undergraduate nursing studies in the previous year, as she now desired to become a registered nurse.

She noted surprise with the lengthy psychological impact of the incident, as she identified having been in two previous motor vehicle accidents of much greater damage. The first of these occurred approximately 25 years ago, with the second 10 years ago — leaving her with a traumatic fracture of her right leg from which she experienced occasional residual discomfort. In both cases she noted a transient and relatively minor subsequent apprehension of driving situations, lasting no more than two months — at which point she had "shaken it off."

Maureen denied any previous experiences of depression or anxiety and reported no previous contact with psychological or psychiatric services and had no relevant previous injuries or illnesses. She denied any use of medication or drugs and described her use of alcohol as "rare" and "social." Prior to the incident, she claimed to have been a "confident and experienced" driver, used to driving long distances from her acreage property to work and university — both within congested traffic.

TREATMENT GOALS

Agreed goals for treatment were as follows:

1. Significant (or complete) phobic symptom reduction, both as a driver and passenger;
2. Significant (or complete) phobic symptom reduction as a passenger;
3. Complete phobic symptom removal as pedestrian; and
4. Development of relapse-prevention, coping and emotional resilience strategies.

The indicated approach was to be that of gradual desensitisation within a structured cognitive-behavioural approach, in this case developed from the framework of Bruce and Sanderson (1998) as represented below:

1. Assessment and client engagement
2. Treatment for phobia:
   (a) psycho-education
   (b) preparation for exposure relaxation – coping behaviour – cognition
   (c) exposure and desensitisation work
3. Review/relapse prevention for phobia.

There had been no discussion of adjunctive hypnosis, at that stage.

TREATMENT AND PROGRESS

Session 1

Assessment and engagement of the client and situation.

Session 2

Psycho-education with regard to phobic phenomena and development of relaxation and stress management techniques.

Session 3

Examination of cognitions and development of cognitive and coping strategies.

Session 4

Preparation for imaginal exposure.

Session 5

It became apparent at the fifth session that Maureen was experiencing very limited gains and was now even becoming more fearful and despondent of her driving difficulties. She had also cancelled two appointments at late notice up to that stage.

Thus an alternative strategic approach was utilised at session 5, with a pause to reconsider the presenting situation. When asked, "What is stopping you from overcoming the phobia?" (a revelatory strategic question of Bandler & Grinder, 1982a) she replied that she could not believe in herself enough to do it. Further probing allowed a social picture to emerge that had not been fully admitted to earlier — her driving difficulties were found to be the butt of family jokes and that her husband and children were either scornful of or dismissive of her problems. She told me that her adult children had told her she "must be stupid" and were more critical of her in many other ways since the development of the phobia. When in the car with her, they were unsupportive and as drivers they "drove too fast and scary." She noted that they "tutted" her and complained when she attempted to drive the car with family members as passengers and that she had long since lost confidence as a driver altogether. She believed that she would not get over the phobia — as she had experienced it for so long and because her children had told her that she would not be able to recover.

I introduced the notion of hypnosis at that stage, suggesting that greater desensitisation gains may be made within that medium and also that, if successful, Maureen might be able to "re-experience" greater confidence in herself, thereby acknowledging previous skills and suggesting that prior positive experiences might return.

As she was quite tense after these revealing comments, the session continued with an agreed small diversion of progressive relaxation followed by a short exercise of guided imagery to explore a favoured outdoor place under pleasant weather conditions. This session proved very successful, Maureen indicating her capability to visualise her parents' acreage, even able to note sounds and identify livestock. Her facial complexion and expression also altered substantially, suggesting to me that she had, in fact, entered some semi-hypnotic state. This experience was discussed with her within the debriefing — and the possibilities of formal hypnosis explored to her satisfaction.

Session 6

The sixth session involved further preparation and discussion of hypnosis, followed by eye fixation induction and gradual deepening with a walk down a pleasant and green-hilled landscape to a refreshing stream. This metaphor was then expanded upon, with a further walk to a large calm lake. On the shores of this lake she was able to sequentially discover three beautiful pebbles of serenity, courage and confidence — that were duly thrown into the lake and watched as they descended down to the deep depths of the lake.

On returning from the lake, I offered the post-hypnotic suggestion that this was a personal landscape of courage that she could return to whenever she wished — at which point her expression changed, in a startled grimace, and her neck arched away from me, as if having imaginally seen something striking. In a moment, the expression changed to a broad and previously unwitnessed grin, which I allowed her to enjoy before encouraging a diversionary route back to a slow ascent of the hill and to normal consciousness.

Maureen maintained this grin in the debriefing of the exercise that revealed that she had enjoyed this session most vividly. The session had been punctuated at the end by her path running across an elk. She described a large, heavy-antlered male elk that had stood steadfastly in her route, but had meant no harm. She indicated that she had always loved elk, as she had admired their strength, courage, calm and dignified demeanour — and that they (and this particular elk) were lords of their land. Thus she had been able to symbolise the desired internal conditions of confidence, courage, and calm within the symbolic presence of a large-antlered elk.

She further revealed that she had always loved all things to do with North American Indian culture, including a piece of music that she had once heard, but had not been able to find in a music store. She volunteered that she might now try once again to find that music, which she was sure could assist her in the car.

Following this lead, I enquired what she currently listened to in the car, having previously discussed the dangers of listening to the woes of the news and talkback radio that she listened to. She then told me that she was playing a great deal of 'delta blues' in the car, a raw and emotive style of Southern blues music. It transpired that she was extremely susceptible to imagery from such music, in an analogous manner to her susceptibility to negative comments from her family. Thus much time was spent discussing possible strategies to garner support from driving companions and revising potential "affirmative"

and "coping" music that she could listen to in the car. She felt and appeared much enthused and engaged with devising her "driving tapes," being more comfortable with her contribution to working on problems through this activity. Indeed, the therapeutic rapport was enormously improved from that point — and in essence, no further problems were encountered.

That session continued with further hypnosis and some desensitisation using previously discussed techniques, except with a prompting that the elk would be watching over her and that was greeted with a grin.

Sessions 7, 8, and 9

Maureen's demeanour was quite different by the next session, with a smile on arrival and a discussion of how she had tracked down a CD of American Indian music that she played in the car and felt "inspired" by. She had also attempted to find a model elk from a toy store, but without success. She also finally indicated a quantum positive change when reviewing her desensitisation hierarchies.

Further exposures took place with hypnosis, although an additional ninth session was required to be scheduled to appropriately address relapse prevention. At this stage she was leaving for university at a normal time — but one outstanding issue was that she had not been able to attempt to cross a major road as a pedestrian for some weeks, as she lived in a rural area and rarely attended busy centres. As my office is located close to a busy intersection, we thus engaged in some in vivo desensitisation as a final activity. She seemed to develop some discomfort at a later stage of this, when requested to cross the rather noisy road alone. At this stage, I reminded her of the elk waiting for her across the road, at which point she closed her eyes for a moment and then crossed uneventfully.

DISCUSSION

The effectiveness of hypnosis as an adjunctive element in the treatment of phobia is well represented in the literature and favourably reviewed by Evans and Coman (1998) and by Crawford and Barbasz (1997). This usually takes the form of hypnosis as a medium for desensitisation processes using ideomotor signalling, although excellent results are equally possible with imaginal desensitisation alone (Wolpe, 1990; Andrews, Crino, Hunt, Lampe, & Page, 1994).

In this instance, the initial progress of non-hypnotic treatment was being possibly undermined by some less well-understood ecological factors, these

being the negative communication of the family — and possibly the detrimental effect of listening to delta blues. In prior assessment, the level of this negativity had not been revealed and no assessment of music had been made, beyond the discussion of the news and talkback radio she had listened to.

The negativity of family driving companions is appreciable, as it is an essential element of such work to have "supportive others" in overcoming phobia (Bruce & Sanderson, 1998). Assertiveness and esteem are further associated common problem areas in persons with anxiety and phobia conditions (Bourne, 1995), both of which require redress — once the scale of the problems have been revealed. In this case, some time was offered to look at assertiveness skills and issues, finding that Maureen's assertiveness and esteem were most problematic in driving, but less deficient in other situations. Thus the symbol or metaphor of engaging the elk was understood by the client as being a mechanism to cue strength, courage and confidence (and therefore self-esteem) as a precursor to engaging necessary assertiveness skills. Interestingly, Maureen indicated that some gains from overcoming her phobia had generalised as enhanced social, work, and study performance and a greater sense of satisfaction in achievements. She was pleased to state that one of her daughters had told her how pleasantly surprised she had been by this later improvement.

Self-esteem was also initially invoked and developed through the imagery of the lakeside visit, with ego-building in the form of symbolic pebbles that were thrown far out into the lake — this metaphor being developed from Stanton (1991). In this metaphor, the lake may be taken to represent the unconscious, with further indirect deepening as the pebble descends "down, down, deeper in the still deep waters . . . etc."

While distraction techniques, usually including music, have some support as strategies to work with phobia (Blaszczynski, Panasetis, & Silove, 1998), there is a danger that as they represent a temporary escape from the feared situation, they may be less strategically beneficial (Bruce & Sanderson, 1998). In this case, however, the specific choice of music can be seen as effective in replacing music with depressogenic elements and as being therapeutic as "anchor" (Bandler & Grinder, 1982b) for a positive experience and disposition.

Furthermore, the impact of music itself must not be underestimated, as it has "powerful effects on consciousness" (Walker, 1992, p. 117), thus making the case for a proper consideration of the music chosen by persons with a car phobia a matter of clinical interest. At the same time, music then offers itself as a therapeutic tool in the context of hypnosis with phobic work, as used by

Milne (1988), although music was not directly used for that purpose in this case.

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Hypnosis in the Treatment of an Eating Disorder

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This case history presents the use of hypnosis in the therapeutic management of a young man experiencing both an eating disorder and exercise compulsion. A range of direct and indirect techniques were utilised as an adjunct to therapy and the case clearly demonstrates the effectiveness with which these can be integrated into a range of treatment approaches for eating disorders.

PERSONAL INTRODUCTION

As with every Monday morning, I woke up at 5.30 a.m. put my togs on and began my 10 kilometre run. At first my muscles were cold and my movements slow and deliberate. The early morning darkness seemed to accentuate my worries about the trials and tribulations of the day ahead. As I continued my run, however, I began to relax into the moment and appreciate the gentle rhythm of my feet on the ground. As the sun began to rise, I began to feel an ever increasing sense of warmth, relaxation and vitality that running produces in me . . . and more and more I became tuned out from the external world . . . and absorbed in my own world of stillness, thoughts and images. My earlier forced and deliberate movement was replaced by gentle easiness, introspection, and an increasing sense of euphoria as the worries about the coming day disappeared.

Suddenly and explicitly the vision of Tim, one of my patients, popped into my head. Tim had been consulting me for treatment of his eating disorder and exercising addiction. The previous day he had described the euphoria, sense of congruency and control and completeness he experienced when running. While I was on my run this morning I suddenly realised that what Tim was

describing, and what I too was experiencing at that moment, was nothing else but a trance, and that I would be able to assist Tim dramatically if I could help him use this capacity to empower him to deal with his problems and unleash his potential. This thought excited me as I continued to run in my own trance-like state. As I reached the top of the hill I had become aware that I had run the last kilometre or so without being aware of it and without experiencing much pain at all, in a very similar fashion, I suppose, to what Tim would have experienced.

This case study describes my efforts to help Tim use this "trance potential" to effect positive change and balance in his life.

REFERRAL BACKGROUND

Tim, a 22-year-old university student, was referred by his psychiatrist to the Eating Disorders Programme at the clinic where I am employed. His primary diagnosis was anorexia nervosa and what his referring psychiatrist described as "exercise addiction" (which has been referred to as "anorexia athletica"). Tim was referred to the programme because of the need for more intensive treatment to manage his problems.

The Eating Disorders Programme is holistic, addressing all aspects of eating disorders. Treatment is geared towards eating disorders such as anorexia and bulimia and interventions include:

• Monitoring of medical and nutritional states;
• Group work (including cognitive-behavioural therapy, assertiveness training, and anger management);
• Psycho-educational groups (education about eating disorders) for patients and family;
• Family therapy; and
• Individual therapy.

While Tim attended all aspects of the programme my involvement with him was exclusively for individual therapy, which he attended on a weekly basis as an in-patient and then as an outpatient. At the time of writing this paper, I had seen Tim for approximately 25 sessions and still continue to see him.

PRESENTING PROBLEMS

Tim has a 3-year history of over-exercising and food restriction and, at one stage, lost 15 kilograms over a 3-month period. He describes his problems as

beginning while he was on scholarship. As is typical of anorexia, his problems began with an extreme concern over body image. His drive to lose "puppy fat" resulted in him exercising to the point that it became an addiction that he could only satisfy by constantly pushing himself through the pain barrier.

At the time I was seeing Tim he had been — and was still — exercising for up to three hours daily, and this included running, rugby, aerobics, cycling and gym. His weight was significantly below the average and his food intake was rigidly restricted to small portions of non-fatty food. His father suggested the possibility of secret bulimic episodes.

He also presented with a history of depression, which had become especially apparent during his adolescent years. Symptoms included recurrent periods of low and flat mood; interpersonal withdrawal and vegetative signs such as concentration difficultes and insomnia. At the time of admission to the clinic for treatment his mood was described as very depressed.

Although Tim's health was essentially good he has suffered from testosterone deficiency as a result of his condition and this is currently being treated. Besides this he does not have any other major physical problems.

FAMILY AND GENERAL BACKGROUND

Tim describes his early childhood as being quite "privileged." The fact that his parents were very wealthy resulted in him feeling "different" from others. His parents were very permissive and he experienced little discipline as a child. Although he describes his relationship with his parents as being "quite good," he felt a compulsion, beginning during early childhood, to please his father and live up to his expectations. This would manifest later on in his life in events such as choosing to enter the same career as his father in order to satisfy him.

His parents' relationship was characterised from the onset by tension, which they coped with by withdrawal and detachment. As a child Tim began to feel "protective" towards his mother because she found it extremely difficult to stand up to her husband. His parents' divorce, when Tim was 17 years old, increased his sense of responsibility towards her. He continued to stay with her and when he left home at the age of 23, he did so with some difficulty because of the fear that she could not cope without him. His three older brothers reinforced this by their "silent expectation" that Tim be the responsible one in the family.

Tim and his family migrated to Australia when he was 10 years old. This had a profound and enduring effect on him. The familiarity and safety that he experienced prior to this was shattered and he began to experience an increasing sense of "not belonging." At school he found it difficult to make friends and would draw attention to himself by obnoxious behaviour. This culminated in him being asked to leave his school and instilled in him a deep sense of shame in himself. His isolation and sense of social exclusion continued at the new school. He became increasingly withdrawn and introverted and as he entered adolescence he found it extremely anxiety-provoking to interact with girls.

Tim is currently completing a higher degree at university. He is required to work at university as part of his programme, which he finds very demanding. He has little time for social activities although he has recently started dating for the first time in a couple of years. He shares accommodation with two of his friends with whom he "gets along" although he becomes frustrated at times with them.

PSYCHOLOGICAL THEMES

Tim refers to his over-exercise and his secret eating as a "displacement" for other problems, including low self-esteem, interpersonal problems, and an acute sense of shame and doubt. His shame and doubt or what he describes as his "social ineptitude," is linked to his sense of being different from others since childhood, and he still feels a sense of shame around the obnoxious behaviour he engaged in as a child.

Tim's low self-esteem is expressed in self-defeating core beliefs and assumptions such as "if people get close to me, they will see I am internally flawed" and "other people are better than me and my feelings and thoughts are not normal." The impact of this low self-esteem and inadequacy is especially evident in his interpersonal relationships and fears around intimacy.

Tim also described his eating disorder and over-exercising as "my way of controlling myself," or dealing with the inner turmoil he experiences. Linked to this are his high rigid and perfectionist expectations of himself and his need to have his world structured and organised.

Tim is acutely aware of a loss of balance in his life. He is aware that he is over-exercising and under-eating and has a high motivation to acquire more balance in his life.

GOALS OF THERAPEUTIC MANAGEMENT

The main goal of therapy — conjointly decided on at the beginning of our therapeutic contact — was (in Tim's own words) to help him achieve more "balance in my life." In these terms, an obviously prime goal of therapeutic management was to increase Tim's sense of balance around his food intake and over-exercising. Related goals included identifying and challenging negative core beliefs underlying his problems, improving self-esteem and general coping strategies, and improving the quality of his interpersonal relationships.

HYPNOSIS WITH EATING DISORDERS

Hypnosis can be used for a variety of purposes for eating disorders. These include reducing hyper-arousal (relaxation training), altering body image, increasing food intake, and recovering possible traumatic events at the source of the disorder (age regression and abreaction), developing introspective awareness, overcoming resistance to change (which is characteristic of this condition), developing more balance and a healthy lifestyle, increasing assertiveness, and heightening self-confidence and interpersonal effectiveness (Griffiths, 1998; Hammond, 1990).

   Two important points need to be emphasised about the use of hypnosis with eating disorders. The first is that hypnosis should only be used in the treatment of eating disorders in the context of a comprehensive intervention programme, which should include a focus on family dynamics, psycho-education and medical interventions. The second is that eating disorder patients tend to be good hypnotic subjects because of their capacity to dissociate.

APPLICATION OF HYPNOSIS

The use of hypnosis typically consists of four major phases: preparation, induction, utilisation of trance, consolidation of trance learning. These phases were applied to the present case in the following way:

Preparation

In this phase the therapist acquires information about the client's "world view," cooperatively establishes desired changes, educates about the nature of hypnosis, establishes trust and rapport, creates expectancy, and indirectly evaluates trance responses. My understanding of Tim's world view emerged

from the sessions we had together prior to hypnosis. Perhaps it can be captured by the following brief descriptions: intelligent student; high insight and self-awareness coupled with emotional detachment and difficulties with acting on his awareness; extremely high energy and focus on sports and exercise, with few other interests; energetic and enthusiastic but obsessional, rigid and "unbalanced."

Rapport and trust had clearly been established between Tim and me prior to using hypnosis, which made the task of setting goals for hypnosis easier. Consistent with the central goal of our therapy — to achieve more balance — Tim and I cooperatively discussed how hypnosis could foster this process by:

- Helping him to mobilise his internal resources and the power of his unconscious to promote balance, change, and general self-actualisation;
- Assisting him to relax more, be less rigid and more flexible;
- Helping him achieve more balance especially in relation to his food and exercise problem, and increase his sense of self-control;
- Increase his sense of confidence and self-efficacy and decrease his sense of shame and self-doubt; and
- Improve his interpersonal relationships.

Tim was considered suitable for trance work primarily because of his natural capacity to dissociate, which is often observed in eating disorder patients. The "high" that he experienced when exercising was characteristic of a trance. He described this as a feeling of total peace and satisfaction, a time when his worries disappeared and he became absorbed in the moment "like a king of the world." During our sessions, his eyes would often drift away in spontaneous dissociation. On one occasion I stopped Tim when he did this and asked him what was going through his mind. He replied that he felt detached and focused on thinking about the exercise he was going to do that afternoon. I suggested to Tim at this point that what he was doing was nothing other than going into a very relaxed trance, and emphasised that he had the capacity inside himself to put himself into a trance. I also suggested that he could begin using this capacity to effect change in his life through hypnosis.

Induction

Keeping in mind Tim's capacity to achieve trance, I waited for the right moment to begin using hypnosis. This occurred after Tim returned from a

three-week holiday. He reported having felt very relaxed and "balanced" while on holiday but now nervous that this feeling would be "eroded" by the stresses of work and daily living. After exploring this (out of trance), I spontaneously utilised a permissive and non-direct general relaxation and breathing induction to facilitate a light trance and then asked Tim to recapture the experience he felt while on holiday and to communicate this to me in his words.

In a slow and soft voice Tim verbalised the following: "stomach feels relaxed, head feels clear and warm, no pain, energy is flowing through my arms and legs, no obligations to go anywhere, no expectations on me, healthy blood flowing through my body, light and clear, no headaches."

After asking him to describe his most relaxing moment while on holiday, he recalled the feeling of peace and relaxation he felt while watching a cricket game on Boxing Day. In future sessions I often used the words that Tim had generated to describe his sense of relaxation as a means of trance induction. For instance, in one session I asked him to sit back and relax and get in touch with his breathing (breathing and relaxation induction) and while he was doing this, to image himself being back at the cricket game, and to recapture the sense of relaxation he experienced there.

In line with indirect inductions, I was conscious of using the following strategies as a means of inducing trance:

Pacing and Leading   I used pacing and leading as a means of initiating the process of directing and absorbing Tim's attention. For example: "and, as you sit comfortably on the chair, you may become aware of the gentle hum of the air conditioner in the office . . . the feel of the chair as you rest against it . . . the sounds of the birds outside *[all pacing statements]* and an increasing sense of relaxation and comfort inside your body *[leading statement]*." I was also aware of utilising non-verbal pacing cues, for instance, speaking in a soft and slow voice the more I wanted to absorb Tim's attention.

Utilizing Minimal Cues/Ratifying Hypnotic Responses   Minimal cues refer to the subtle changes in the person's behaviour, which can be utilised to enhance trance. Examples of such minimal cues with Tim included: "yes, notice how your breath becomes deeper and more rhythmic which can be a sign that you are becoming more and more relaxed" and "those twitches in your fingers can be a sign that you are going deeper and deeper into trance."

Embedded Suggestions   Embedded suggestions (Bandler & Grinder, 1975) refers to the process of interspersing indirect suggestions unnoticeably within a set of statements, usually by non-verbally marking out certain messages.

Tim's own words were utilised in embedded suggestions. For instance, the words he had used to describe the sense of relaxation he had experienced while on holiday were interspersed with general relaxation suggestions throughout the induction. For example: "let that **clear and warm** [his words] feeling continue to **flow** through your body . . . and perhaps you can notice the **healthy blood flowing** through your body and feel secure that there is no **obligation** and no **expectation** to experience anything you don't want to . . ." Examples of other embedded suggestions with Tim include ". . . and people can **begin to relax** in their own way and I wonder how you are going to let yourself **go into trance today**."

Pre-suppositions   Pre-suppositions essentially refer to questions that are phrased in such a way that they assume a hypnotic response will occur. I used a variety of pre-suppositions throughout inductions, including such examples as "and I wonder how much you are going to let yourself relax today," and "I am curious to know how much balance your unconscious will allow you to achieve."

Dissociation   Dissociation refers to the splitting of conscious and unconscious processes in order to deepen trance. An example of a dissociation that I used in trance induction with Tim was: "your conscious mind might be thinking about the day gone by or even about problems or concerns . . . while your unconscious mind is absorbing what I am saying on a deeper level."

Deepening   Methods that were employed to enhance Tim's trance experience included pleasant place imagery, silence and compounding. For pleasant place imagery suggestions were offered to Tim that he imagine himself being at the cricket game where he was on holiday, and experience the same sense of relaxation that he experienced then.

Silence was used by suggesting to Tim that: "in a moment I would like to let you have some time to sit there silently as you are doing now and continue to enjoy the experience and to become more and more relaxed . . . more deeply and deeply absorbed . . ." Manual compounding is a deepening method and refers to the linking of suggestions of deepening with physical sensations that reinforce the suggestions. For example, with Tim I said: "as you become more relaxed, you can let yourself go deeper into trance."

Establishing Desired Changes

The focus of this phase is on achieving the desired therapeutic change through the utilisation of trance.

The initial goal of trance work was to induce relaxation, which is an important aspect of trance utilisation with eating disorder patients. Two sessions were devoted to relaxation-hypnosis, using both direct breathing and relaxation inductions and more indirect relaxation techniques and imagery as outlined in the preceding section.

Two sessions focused on ego-strengthening to raise self-esteem, and the mobilisation of his inner resources and the power of his unconscious mind. Interspersed with ego-strengthening suggestions were suggestions revolving around the following: "you have shown you have the power inside yourself to achieve trance . . . and it is this power that you can begin utilising to achieve your goals . . . to achieve balance in your life. Starting from now you can learn to trust yourself more . . . to achieve what you really want. You may be surprised how you can use the power of your unconscious mind to achieve balance and flexibility in your life. I wonder how your unconscious power is going to allow you to achieve balance and wellbeing. Starting from now you may be able to feel good in other ways besides just exercise."

The next session focused more specifically on achieving balance in relation to over-exercising and to some extent under-eating, using the healthy voice versus the self-defeatng voice metaphor, a metaphor which is often used in the treatment of eating disorders. We began (out of trance) conjointly uncovering the following negative self-statements typical of the self-defeating voice, most of which had already emerged over the course of therapy:

- "I should always exercise until I am exhausted."
- "I have no control over my exercise routine and diet."
- "I should rigidly stick to my programme."

Tim was then helped to generate an adaptive healthy voice statement to counter these negative statements:

- "Exercise is good in moderation. I don't need to overdo it."
- "I can control my exercise routine and diet."
- "I can be flexible about my exercise routine."

While in trance I spoke to Tim about aspects of the unhealthy voice and his healthy voice that we had generated and then asked him to repeat silently each coping statement that we had generated, giving him a couple of seconds to absorb each statement.

A session was also used to assist Tim achieve balance through increasing his sense of control and effectiveness. A simple projection script based on the

combination of a triple screen approach (neurolinguistic programming) and suggestions for increasing a sense of control and effectiveness in anorexics (Hammond, 1990) was utilised. While in trance, I asked Tim to imagine himself on the left side of the triple screen in terms of all his negative qualities and then, after imagining that he had received appropriate treatment (in the middle screen), to imagine himself as he would like to be five to ten years from now. I interspersed suggestions around imagining himself being in control of his life, his exercise, and his eating.

OUTCOMES AND RETROSPECTIVE COMMENTS

Tim was a good candidate for trance work as reflected by hypnotic phenomena which he exhibited including facial and hand twitches, fluttering of his eyes, gradual increase in the depth of his breathing, and his general relaxation response and body stillness.

His capacity to spontaneously dissociate, as already mentioned, as well as his compliance and general need to please me — which I had observed during our longstanding therapeutic relationship — increased his responsiveness. After each session Tim reported feeling more relaxed and vibrant and partial amnesia for the hypnotic process was observed as well as time distortion (I used this as part of trance ratification). After using hypnosis with Tim I continued to reinforce the theme of achieving balance, out of trance. I also continued to use cognitive-behavioural techniques to help him challenge underlying self–defeating core beliefs that we had identified; and behavioural techniques to help him plan more balanced goals around exercise and food intake.

Tim began to demonstrate a slow and gradual improvement in the following areas:

- He began to plan and maintain a more balanced exercise schedule.
- He began to invest more energy in other areas of his life, such as his studying and his relationship with his girlfriend.
- His dietician observed a small increase in his food intake and a generally more balanced diet.
- He showed some evidence of becoming more aware of bodily triggers associated with over-exercising and his ability to act on these triggers by lowering his exercise.

His progress was far from miraculous, however, and he has experienced a number of lapses in the form of "exercise binges" and restricting his eating in the last few weeks. A positive aspect of this, however, is he is fully aware of,

and able to articulate well, the triggers for these binges, the underlying reasons, and possible strategies to prevent further binges or lapses. Tim is still consulting me on a weekly basis and I plan to decrease the sessions to twice monthly in order to continue monitoring his condition and reinforcing the themes we have explored in and out of hypnosis.

In retrospect a number of areas could have received more attention with hypnosis. Hypnosis could have been used more intensively to assist Tim to challenge negative core beliefs underlying his maladaptive behaviour. These tacit beliefs have been found to be responsive to hypnotic interventions. Hypnotic age regression techniques could have also been used to help uncover negative core beliefs and painful feelings — for instance, the early shame that Tim experienced — behind his problems. More techniques could have also been used to facilitate an increase in introspective awareness, although much work on this was done out of trance.

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USING IMAGINATIVE INVOLVEMENT TO HELP
A CHILD CONTROL HIS BEHAVIOUR

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This case study illustrates the use of imaginative involvement to overcome a behaviour management problem. Details of a successful intervention with mother and child are described. Although hypnosis was not mentioned nor deliberately induced, therapeutic outcomes are arguably attributable, at least in some measure, to hypnotic effects. The case illustrates many of the points made by researchers and clinicians in using imaginative involvement and hypnosis when working with children. As an aid to understanding the case, background material on the child's mother (the original client) is also presented.

PRESENTING PROBLEM

Patricia was referred by her GP, who was concerned about the effects on her health of worry about (a) Patricia's poor marital relationship, and (b) her children's behavioural problems. These had led to sleep disturbance, heavy smoking which exacerbated some other medical conditions, frequent headaches, nervous tension, and irritability. The GP had prescribed medications for some of these symptoms although routine medical examinations found no physical causes. A teacher had suggested medicating the son (for attention-deficit hyperactivity disorder?). Medical examination indicated both children were healthy and their developmental milestones were normal. The GP had persuaded Patricia that medication was not the answer for either her or the children. Patricia reported that both children were unruly. Her priorities were:

1. To better manage her son's behaviour (he was on the verge of being

expelled from school for verbally abusing teachers and physically abusing other children);

2. To better manage her daughter's behaviour (which was bad but much less severe); and

3. To get a fairer deal in her marriage with regard to sharing parenting, housework, and financial resources (this problem she ranked last as there was no emergency and the prospects for improvement were poor — her husband refused to acknowledge any difficulty with their relationship to each other or the children, and was hostile to the idea of counselling). She felt that she and her husband tended to "lash out" at each other and the children, just as their own parents had done, and hoped counselling would help.

Personal Presentation

Patricia was a vivacious, slender, attractive woman of 38. She behaved with cheerful self-assurance, although she looked worried when discussing her family problems. She seemed like a sensible, intelligent woman trying hard to do the best for her children, despite the lack of support from her husband and the poor example from her own family. She demonstrated a willingness to accept responsibility for her own contribution to the situation, and high motivation to solve the problem. There were no signs of psychiatric illness, depression, or anxiety beyond what would be normal in the situation.

Social History and Context

The family consisted of Patricia, 36; Robert, 36; Robin, 6; and Paula, 5. Patricia and Robert have been married for 12 years. Both work full-time, the wife in an administrative position and the husband as a truck driver. All her salary goes on supporting the family. Aside from paying the mortgage, Robert spends all his income on himself and she does not know what he earns. Patricia completed the HSC, Robert left school at 14. She is studying part-time to gain tertiary qualifications in line with her employer's expectations. Robert's job takes him away from home a lot, so Patricia has the full care of the home and children, who attend after-school care daily. Although Robert's family live nearby they are not helpful. Patricia's mother and sisters would assist but live some distance away. She has several women friends who are honorary aunts to her kids and very supportive in emotional and practical ways.

Both Patricia and Robert came from abusive backgrounds. Robert's father physically beat up his sons. The relationship is still very antagonistic: fisticuffs frequently break out between brothers, and between the father and sons. Patricia was sexually abused by her father between the ages of 11 and 15. The sexual abuse stopped when she told her mother, who left the father and had him prosecuted. Patricia is on good terms with both her parents these days. She explained that she loved both of them dearly. She seemed to believe that they were fallible human beings who had behaved incompetently but not maliciously. Patricia felt her father had been justly and sufficiently punished by the break-up of the marriage, the prosecution, and the public humiliation. He had expressed remorse and asked her forgiveness in recent years, which she had granted. When asked how this was possible she said, "I hate what he did, but I love him." She explained that although her mother was "on a short fuse" and was very inconsistent with her rules and punishments for her children, she had "always been there" for her kids. Furthermore, when the abuse was revealed she acted swiftly to protect her daughters, and apologised to Patricia for not having spotted the problem. A few years ago she had passed on her pastor's suggestion that the three of them get therapy to help them "heal the past." Patricia had refused on the grounds that it was irrelevant — as far as she was concerned it was healed. Patricia told me matter-of-factly that she saw no point worrying about past history which could not be changed, she would rather think about improving the future.

Robert cannot stay out of trouble and is currently on several assault charges. (This appears to be a family tradition — other males in the family also tend to get into pub brawls, etc., and make frequent court appearances.) He is not violent to her or the children, although he is verbally abusive when thwarted or annoyed. Due to his occupation (and possibly use of drugs to keep awake on long shifts) he is often sleep-deprived, moody, and quick-tempered. He finds it acceptable that his children copy his use of obscene language, and sees his son's tendency to pick fights with other boys as normal male behaviour. The family have little time together, the couple still less. When Robert is away she gets the kids into a routine — they have fixed meal and bed times. A bedtime ritual includes Patricia reading a story to them. When Robert comes home he expects that this schedule be varied unpredictably to suit his preferences, which leads to marital fights.

Despite her history of abuse, Patricia has always enjoyed sex. Initially they had a very affectionate, passionate relationship. Since the children were born her resentment over his lack of support has steadily increased and she has lost

interest in sex. When rebuffed he accuses her of infidelity. He frequently has jealous tantrums over other men's attention to her in social situations, including her father. His moods have deteriorated since he became a truck driver. She has asked him to change his occupation with its attendant stressful and unhealthy lifestyle. He refuses to discuss any of this. They separated twice before the children were born — once over his affair with another woman, and once over his financial irresponsibility.

Everywhere but at school, Robin's behaviour is very polite and cooperative. The disobedience reported at home appeared on closer examination to consist of relatively mild instances of non-compliance, often because Patricia's rules were too strict and her disciplinary responses too inconsistent. At school he is frequently on detention for blatant acts of unprovoked violence. The most recent instance involved deliberately stamping on another child's foot under the eyes of the teacher, to the rowdy acclaim of his mates. The school finds this behaviour baffling and inexplicable in such a winsome, intelligent child. His teacher reports that he reads and writes above grade level, completes his class work easily, and is friendly and cooperative when he is not attacking other children. He accepts his punishment without demur, and has always behaved impeccably in after-school care. Some of his friends at school are considered by Patricia to be a bad influence — she thinks he may act "macho" to impress them — she does not let him invite these boys home. He is kind to his little sister and they rarely have more than a brief squabble. He behaves in an appropriate way with friends of the family and in church.

Despite his father's bad temper and infrequent contact, Robin adores his dad. He insists on wearing the same coloured T-shirts and shorts so that they can "be a team." He bears a striking resemblance to both his father and grandfather. His father hates his grandfather but is considered a "chip off the old block" by all and sundry in town. Both men are considered by women to be handsome, charming, and sexy. Equally, both are considered by men to be very quick-tempered and unreasonable.

Patricia told me that she would probably leave her husband if things did not improve but she was not ready to go yet. She is a devout Christian, and considers divorce against God's will except when there is a serious violation of the marriage contract, and/or danger for the children. Her pastor is encouraging her to stay with the marriage. The social standing and support she receives from her activities in the parish seem to be very important to her. Her husband has no religious affiliation.

Robin's Problems and Treatment Approach

Robin was following blindly but loyally in a family tradition in which poor impulse control was seen as synonymous with masculinity. (He was probably also confused by the rather erratic disciplinary methods in the household.) I did not think he would be able to give any satisfactory account of his bad behaviour and was probably as baffled and distressed by it as everyone else. Since the motivation for all this was assumed to be outside of awareness it was quite congruently dealt with the same way. Furthermore, there appeared a problem with identity and socially constructed gender roles. It is hard to know what a direct broaching of these issues with a child would provoke to the greatest degree — bafflement, boredom, or embarrassment.

Personal Attributes

Robin seemed to be a smart, normal, healthy kid with good powers of concentration. I knew he was in the top reading group at school and loved to read fiction. Because of the literal thinking style of children of his age and their love of fantasy, I thought I could appeal to his imagination. We had an instant rapport and he was ready to cooperate with me.

He had no knowledge of hypnosis and suitability was not assessed in any formal way. There appeared no contraindications. He was taking no medications, had no other known medical or neurological problems, seemed keen to cooperate, and there was no reason to suspect severe pathology. In any case, no formal induction was attempted and the word "hypnosis" was never mentioned. Therefore neither apprehensions about hypnosis nor informed consent were at issue.

TREATMENT PLAN

We agreed to make helping Robin the first priority, since his life was pretty miserable. He was spending every lunchtime in detention and was in danger of being expelled with one more misdemeanour. I asked Patricia to bring him to see me. My treatment plan included using storytelling and imaginative involvement to suggest ways the child could take responsibility for keeping himself out of trouble, and thereby avoid invoking any guilt or blame. I had no intention of using any formal hypnotic induction, and did not consider trance was a necessary ingredient of the therapy.

Session 1

Intake interview with the mother.

Session 2

Mother and child.

   Robin is a beautiful child, with large soulful eyes. He greeted me with a big smile. His mother was worried that he would not be able to keep still and I was also a little concerned that my chairs would be too high for comfort. After talking for a while about his interests, I told him I understood that some things were not going well for him at school and that if he wanted to maybe we could do something about that after we listened to a story — Maurice Sendak's *Where the Wild Things Are.* He said that would be okay. He knew the story but wanted to hear it again. (In the story a little boy, Max, is sent to his room for being a "wild thing." Pictures show him attacking the cat with a fork etc. He goes off in a boat to where the wild things are and tames them by staring into their big eyes. They make him their king, and they all have a wild rumpus. The illustration shows him dressed up with a cape and crown surrounded by huge, bulgy-eyed monsters. Eventually he gets tired of this and sails back to "where someone loves him best" and finds his supper in his room. His mother is not illustrated. Although she is unseen, her actions are crucial to drive the narrative.)

   Robin sat motionless and transfixed, listening to the story. He maintained unblinking eye contact with me throughout. When I wanted to show him the illustrations I held the book in front of my face — at the level of my eyes. At appropriate times in the story I drew oblique references between Robin and Max. When I finished reading the story I told him that: "Trouble sometimes creeps up when kids are not looking and gets them to act like Wild Things and IT'S NOT FAIR! Then they might have to stay in the detention room during lunch time when other kids were playing and IT'S NOT FAIR! And the teachers would be tricked into thinking that kid was a bad kid AND IT'S NOT FAIR!" (see summary in letter below).

   I suggested that maybe something like this had happened to him. He listened to all this intently and nodded agreement at relevant points. I suggested that it might help to watch out for Trouble so it did not sneak up and catch him unawares. We talked about spying on Trouble and I suggested we make a list of what he would need in his spy kit. At this point his face lit up, he said, "Good idea," jumped out of his seat, wriggled onto his mother's knee and said,

"Write this down, Mum." He suggested: jars with lids (because sometimes Trouble might pretend to be something very small like a caterpillar); talcum powder to sprinkle on the ground so any Wild Things would leave tracks; a magnifying glass to see the tracks; a Superman Cape and eye mask so Trouble or Wild Things would not know who he was; and a bag to put it all in.

I then suggested that it might be important to announce to other people that they were ganging up against Trouble and said I had just the thing, if they were interested. I had prepared a short declaration of solidarity against Trouble to go on the refrigerator door (see below). They signed, I witnessed and the other family members were to be asked to sign it that night.

Robin volunteered to illustrate this announcement with Wild Things

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IMPORTANT ANNOUNCEMENT

This family is ganging up against TROUBLE!

TROUBLE tricks kids and IT'S NOT FAIR!!!!!

TROUBLE can trick one kid, but not the whole family.

Watch out TROUBLE!

Signed

_____   (mother)

_____   (father)

_____   (son)

_____   (daughter)

_____   (witness)

_____   (date)

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before it was stuck up. The sources for these ideas about spying on Trouble and using therapeutic documents such as the above are Freeman, Epston, and Lobovits (1998), and White and Epston (1990).

During my conversation with Robin, Patricia sat very still and listened intently. At the end of the story I turned to ask her, "Do you see what I am doing?" and she nodded slowly as though coming out of a daydream and said "Yes." Throughout the session (and not deliberately) I kept calling Robin "Robert" and then correcting myself, saying, "Oh sorry you are not Robert are you?" Towards the end of the interview this happened several more times, twice the child corrected me by saying "I'm Robin not Robert," and at the very end the mother corrected me in the same way.

I suggested they come back in two weeks and tell me all the exciting news. They agreed. I said I would be sending them a letter with a summary of our discussion, some of which Robin could read to his dad and his little sister, because he was such a very good reader (I printed the bits he should read in 16 point font):

Dear Patricia,

       Here is a summary of our discussion to help explain our plan to the rest of the family. Robin is such a good reader he might even want to read some bits.

1. We read the story **WHERE THE WILD THINGS ARE.** In the story Max is behaving like a wild thing so his Mum sends him to his room. He goes off to the land of the Wild Things. Even though he is just a little kid, no bigger than Robin, he tames them and becomes their king. We wondered how he did this. The Wild things are SO BIG and Max is only small. We thought, Robin and me, that maybe it was because he was SMART and he had a good IMAGINATION and because he can stare into their eyes without blinking. I was surprised how long Robin can look without blinking. He's REALLY good at keeping his eyes wide open.

2. Robin and I agreed that sometimes TROUBLE can capture a kid's imagination and trick him into acting like a Wild Thing. **AND IT'S NOT FAIR!**

3. I discovered that Robin has a great imagination, just like Max. We wondered how he could use his imagination to help him stay out of trouble. We need to find out more how TROUBLE works so we can see it coming and think of more ways to outsmart it. So we had some questions:

What does Trouble look like in the mind's eye? Like a monster? Like a Wild Thing?

How does Trouble sneak up on kids?

How does Trouble trick kids into acting wild?

4. We decided it might be a good idea for Robin to spy on Trouble. Robin said it would be okay for him to do this. He will need a spy kit for this (with a magnifying glass, and a mask and a disguise and some other stuff). He will find out more about Trouble's sneaky ways and lies. Robin will be watching out for Trouble. He will learn to sneak up on Trouble before it sneaks up on him. Even if he keeps his eyes wide open Trouble might manage to sneak up and trick him once or twice. That will be a good chance to see how the trick works.

5. We have made an important announcement that the whole family will gang up with Robin to help him learn more about staying out of trouble. If anyone has any good ideas please tell Robin. He is going to draw around the edge and then stick the announcement on the fridge to remind everyone they are on his side against Trouble.

6. Next week Robin will tell me what he has learnt about Trouble and we'll start to write a story about it.

7. I am really curious about one thing and I want you to ask Robin to help me find out. Most places Robin stays out of trouble, but Trouble seems to be able to catch him at school. How come? Maybe Robin could practise looking out for Trouble first at home with his spying kit, and later even without his spy stuff he could watch out for Trouble's sneaky tricks at school. What helps Trouble win at school? What helps Robin win everywhere else?

Everyone gets into trouble sometimes, but kids need to learn how to stay out of trouble and tame the Wild Thing. Parents had to learn that when they were kids. Most sensible adults know that there's enough trouble in the world without going looking for it. Maybe there are other people in this family who can think about times they managed to stay out of trouble when it would have been easy to get into trouble? What advice would they give to someone who is trying to stay out of Trouble's way? Robin is a smart kid, and he's learning all the time, so any tips you can give him from your own experience will help him learn even more.

See you next week,

Anne.

Session 3

Patricia came alone. She reported that:

• The announcement was on the refrigerator, with appropriate embellishment;

- They had collected the spy kit and Robin had enthusiastically watched out for Wild Things around the house each morning and afternoon. Talcum powder around the paths, garden beds etc., to indicate the presence of Wild Things, annoyed her but she resisted the urge to sweep it up;
- Her friend had made Robin a cape and mask which he wore at night in bed, and also insisted on taking to school in his bag. Even though he could not use it there, he said it made him feel good to know he had it with him; and
- There had been no further incidents at school (usually there was at least one incident a week when the head teacher called Patricia at work, sometimes even one per day).

Patricia said she had decided not to bring the kids along because she thought their behaviour was up to her. If she parented them well they would behave well. I told her that I agreed with her decision. I said I knew she could manage her situation because anyone who could dismiss the effects of sexual abuse with strength and grace as she had could do anything. We spent the rest of the session discussing various behaviour management strategies, none of which I directly advocated, although I described several in detail. I told her what research told us about how kids learn, moral development, etc., and described ways of shaping behaviour via rewarding successive approximations and ignoring failures. I told her that it was good to teach children how to wait, because kids' ability to delay gratification and control impulses was a good predictor of success in life. We also discussed how Robin's father (and grandfather) had poor defences against Trouble and could not resist their angry impulses when thwarted, and what she could say and do to build up Robin's resistance to these bad examples without attacking his loyalty to his father. She understood how important his identification with Dad was to his sense of who he was and could be, especially with the remarkable family likeness and his hero worship of his father. Strategies included noting how various family members were a bit the same and a bit different, commenting on all the good ways he was like his father, and noting ways he was different from his father and/or like other positive male role models (e.g., You have lovely eyes like your Dad, but his are green and yours are blue. Uncle Stan always loved reading, just like you do).

Session 4

Patricia reported that she had made charts for rewarding good behaviour with gold stars, and that her general management of the children's routines was much smoother. Breakfast time was no longer the tense time it had been. She had worked out with both kids the order of things they had to do to get ready for school and made lists and schedules to cue them. She gave them regular prompts and praise for getting ready on schedule. Previously she had not provided any structure for this activity, nagged erratically, then flown into a rage if they dawdled. She told me proudly of a few other examples where she had taken control of vexing situations rather than let them control her. As Robin's behaviour had settled, she found his little sister's had also improved. She had told her husband that if wanted to help her establish these new routines and programs with the kids she would be glad, but if he had no positive contribution to make not to interfere. He had done nothing to undermine things. So she had solved two of the three presenting problems. There seemed little scope for improving the marriage.

I asked what percentage of the relationship would have to be unsatisfactory for her to leave, and she said 100%. Currently it was only 90% bad. Her husband remained opposed to counselling and with her extraordinary capacity for patience and forgiveness I did not see her either leaving or pressing him hard to change. She agreed with me that essentially her life was one of a single parent with a lodger, and since she embraced that situation with her eyes open there was no room for resentment. I was impressed with her willingness to accept so much responsibility so graciously, and was willing to provide support and encouragement as needed. Although she felt she could benefit by continuing with supportive counselling, she could not afford to. Since she had solved her most pressing problems, therapy was terminated with the understanding that she would return if she needed help at any future time.

FOLLOW-UP

I have not heard directly from Patricia or Robin. Her GP reports she has not been back to him with any of the original complaints, and from casual social observations Patricia and children seem happy and well. Since her GP is a fellow parishioner and his children attend the same school as hers, he would have heard of any school expulsion or other problems and passed the news on to me.

DISCUSSION

This is an example of using a child's capacity to enter make-believe for therapeutic purposes. According to Gardner (1974), a child's talent for hypnosis depends on:

1. Capacity for focused attention, immersion and absorption;
2. Concrete literal thinking;
3. Love of magic and limited reality testing;
4. Intensity of feeling states; and
5. Openness to new ideas and experiences.

Robin showed (1) above in his initial conversation as well as absorption in the story; exhibited (2), (3) and (5) in his response to the story and ready acceptance of the spying game; and (4) in his enthusiastic response to the ideas. It should be noted that the word hypnosis was not mentioned and no formal induction or deepening technique was used. It is widely recognised that many hypnotic suggestions are best delivered indirectly via the use of metaphors embedded in a narrative, and this is particularly true of indirect approaches to hypnotherapy (cf. Erickson & Rossi, 1979; Hammond, 1990; Lankton & Lankton, 1983). With children the boundary between reality and fantasy is not as firm as with adults and one could take the view that: (a) trance may not be necessary for the acceptance of suggestions offered via story-telling; and (b) children will easily slip into trance via imaginative absorption in a story, without any formal induction.

According to Olness and Gardner (1988) there are certain broad indications for the use of hypnotherapy with children. I think the case history speaks for itself in illustrating that the first four were met:

• There was a positive relationship between the therapist and child.
• The child was motivated to solve/remedy the complaint.
• The parents approved of the plan.
• No iatrogenic harm was anticipated or forthcoming.
• The problem had been shown to be treatable by hypnosis.

In respect of the last point, the therapeutic use of stories with children is well documented, both with and without explicit use of hypnosis (see Contos, 1999; Freeman et al., 1998; Gardner, 1977; Rhue & Lynn, 1991; Scott, 1995, 1997). Many hypnotic suggestions are given indirectly via the use of metaphor and narrative (cf. Hammond, 1990). Kuttner and her colleagues (1988) discuss the use of a special story as both an induction and a means of transforming

the interpretation of a noxious experience. The second goal was the only one important to me. Given the ease with which children of that age slip in and out of a fantasy world, it was fair to assume that at least a light trance would be induced and would assist the process. However, that was not my particular aim. The main aim was to offer a reframing of the situation to the child which provided a face-saving exit. The story is archetypal and suggests ideas useful to little kids struggling with their antisocial impulses. It tells them they will be punished if they yield to destructive or hostile impulses. They can escape noxious experience (guilt, punishment) via dissociation — entering into a world of fantasy where unchecked impulse reigns supreme — but in the end this is only a temporary solution and not a satisfying substitute for social connection. And in order to provide the reassurance that it is worth coming back to face reality kids need to know mother (parents) will continue to provide love and comfort (in the form of the supper waiting). It was necessary for Robin to find some ways of keeping out of trouble, and being shamed and humiliated for prior actions had only made it harder for him to renounce that path. Without blaming him, I used his imaginative involvement in the story to suggest ways he could take responsibility for controlling his own behaviour.

Hart and Hart (1998) say it is possible to discern whether children are responding to hypnotic suggestions or not by their narrowed, focused attention and their absorption in images and fantasies. Certainly judged in these terms Robin was very responsive, and in fact showed various signs of trance including:

- Suppression of eye blink response;
- Suppression of swallow response;
- Slow calm breathing;
- Muscular relaxation and absence of any movements (other than requested ideomotor signals of assent) for upwards of 30 minutes;
- No startle response (the back door slammed loudly several times during the story);
- Focus, concentration and absorption;
- Compliance with suggestions for ideomotor responses given during trance (i.e., the story telling); and
- Post–session acceptance of suggestions.

Robin had an affectionate relationship with his mum, who had a friendly, easy relationship with me. It is likely that his mother's presence enhanced the feeling of trust and safety in the session. Like Max's mother in the story, we

knew she was there even though we could not see her. Because she sat out of my field of vision and I was entirely focused on Robin, I could not observe her responses during the storytelling but I wondered subsequently if she had not spontaneously gone into hypnosis. She is probably quite talented at entering hypnosis herself, given that she is an intelligent, intense woman with a history of sexual abuse. Research suggests that abuse (Lynn & Rhue, 1988) or even moderately harsh parental punishment can foster the tendency to dissociate (Rhue, Lynne, & Sandberg, 1995) and enhance hypnotisability. If this was the case, one might assume that she had also taken up the oblique directions about "sneaking up on trouble." This is essentially a direction to assume responsibility for problems and take preventative measures, and following the session with Robin she certainly made big strides in changing her parenting style from reactive to proactive.

The intervention with the child involved only one session with him. Despite his mother's initial concern that he might not cooperate, Robin and I formed an immediate rapport and he was clearly entirely absorbed in our conversation. I wondered if to any extent jealousy over our intense connection had prompted her to decide that she did not want me to continue to mediate the relationship with her son. If so, I am in full agreement with her that as his mum she should be the most important helper in his life. I was happy that the child was doing what was in his power to do, and felt that helping the parent was the best way to help the child further. In any case I always prefer to make the minimal possible interference in other people's lives and therefore tend to keep therapy brief.

CONCLUSION

This was an apparently successful use of imaginative involvement to help a child take control of his antisocial and abusive behaviour towards other children. A story was used as a basis for suggesting a solution to the problem. Hypnosis was not mentioned and no formal attempts to induce trance were employed. There are indications that the child did in fact slip into hypnosis very readily, and if so it might be concluded that hypnosis played an important role in his ready acceptance of both the direct and indirect suggestions for change associated with the story and the spying game. It is possible that the child's mother may have spontaneously gone into trance during the storytelling session. This was not planned, and was neither assessed nor discussed in the course of treatment. If this did in fact occur, the effects appear to have been only beneficial.

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Hypnosis Used in the Treatment of a Chronic Pain Condition

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Joan was 24 years old and had worked for a government agency for three years. She self-referred for pain management treatment in January 1999, through an employee assistance programme (an agreement between an employer and a counselling service to fund the provision of a set number of confidential sessions to any employee regarding any issues they wish to discuss). Treatment took the form of a cognitive behavioural approach over six sessions, four of which utilised hypnosis and teaching self-hypnosis for effective future self-management. After treatment, Joan reported a decrease in her level of pain and an ability to better manage the level of discomfort she continued to experience. On a scale of 1 to 5, her reported pain went from a range of 0 to 4, to a range of 0 to 2; Digesic medication reduced from 10 tablets to 4 per day; and she reported the ability to better manage feelings of discomfort.

PRESENTING PROBLEM

Joan presented as a friendly, gently spoken, and slightly overweight female. She advised that she had sustained a back injury 12 months earlier, when she had tripped over a cord in her workplace. She had been off work as a result for a period of time and was currently attempting to return to work on a graded plan, involving reduced hours and duties. Her current work hours were seven hours per day, five days a week. A recent MRI scan had revealed a leaking disc in her lower back and Joan's current treatment included: physiotherapy, hydrotherapy, Digesic medication and regular consultations with her GP and orthopaedic surgeon. Her major concern was the level of pain she experienced in her back and a recurrent "electric shock" feeling in her left leg. This pain

was so bad on occasions that she was not able to get out of bed. Joan also reported her work regularly re-aggravated her injury, and this had negatively impacted on her return to work. She subsequently felt pressured by her employer and rehabilitation coordinator and felt they did not believe her when she did not feel able to upgrade her hours or duties as outlined in her "return to work plan." Subsequently, Joan had lost all desire and motivation to be at work. She was aware her GP had been told she would be dismissed if she did not maintain her normal hours or had another relapse. She said she worried about the "worker's compensation stigma" and whether she would be able to obtain employment if her employment was terminated. Joan also commented she was cross that she was allowing other people to offend her. For example, she said she knew she was overweight but became irritable when this was brought up by the insurance company and her rehabilitation coordinator.

Joan felt her pain impacted on many different aspects of her life, and that she felt emotional and teary a lot of the time. She rated her pain on a scale of 0 to 5 as reaching 4 at least three times a week and usually remaining around two. Joan also felt fatigued on a daily basis; she slept excessively (could sleep for 13 hours at a time) and experienced a negative impact on her sexual relations with her partner (whom she described as supportive). Joan said she had an irritable relationship with the insurance company as she felt she had to "fight for everything," and had funding for certain tests and equipment refused. The insurance company had recently declined liability for her claim. Other issues included the fact she had envisaged her job as a stepping stone until she started university and later planned to train as a primary school teacher. She said she was frustrated that these goals were on hold due to her injury.

PSYCHOSOCIAL HISTORY

Joan stated her mother had passed away from cancer three years earlier and she had gained 25–30 kg since then, of which she had recently lost 20 kg by going to the gym twice a week in addition to walking regularly. She reported being unsure how long she could keep this up, because she ate more "comfort" foods when she felt stressed. Joan noted changes to her memory and concentration and an increase in caffeine consumption. She also disclosed having attempted to commit suicide several times by overdosing on morphine. Joan said she currently felt down, though not severely depressed or suicidal, and said that on

occasions she felt like hurting someone, but knew she would not act on this because it was not in her nature.

Joan commented her parents had separated when she was two and she had recently commenced rebuilding relations with her father. She mentioned she had a brother who was six years older, with whom she was close, but he did not understand her emotional side because he was a "black and white thinker" with strong coping resources.

Overall, Joan said she felt worthless, as if she had not achieved as much as she had hoped and wondered if she ever would. She reported she had read a lot of self-help books and experienced relaxation/meditative techniques with her mother when she was ill. These techniques had been helpful, but she had not implemented them recently. She had no religious or cultural beliefs contraindicating the use of hypnosis and was willing to try hypnosis, for which she had a positive expectation, given her previous experience with meditative techniques.

TREATMENT PLAN

The following treatment goals were discussed and set at the end of the first session:

1. To reduce her level of pain through use of relaxation and hypnotic techniques;
2. To improve general coping skills by cognitive-behavioural techniques (e.g., teaching assertiveness techniques/conflict resolution and communication skills to assist when dealing with the insurance company and rehabilitation coordinator); and
3. To rebuild self-esteem and confidence through cognitive techniques reinforced using hypnosis.

Hypnotic techniques used included eye fixation, progressive muscle relaxation, guided visual imagery, symptom reshaping by use of metaphor and reinterpreting painful sensations. These strategies were used as they are effective and commonly used techniques for pain management (Hammond, 1990).

SUITABILITY OF CLIENT FOR HYPNOSIS

Although she had not experienced hypnosis previously, Joan was familiar with it and had benefited from using relaxation techniques in the past. She did not have a history of psychiatric illness, did not take any medication that would impinge on or act as a contraindication for hypnosis, nor did she have severe depression with a suicidal component. Although Joan disclosed she had attempted suicide three years previously, she clearly stated she was not suicidal at this time and this was evident by the fourth session of treatment. She did not present as severely depressed, but I was cautious to ensure this was the case before attempting hypnotic treatment. Her attitude towards using hypnosis was positive, although her preconceptions regarding hypnosis centred on stage hypnosis and I educated her about hypnosis for clinical purposes. It was explained I would not, nor could I, make her do anything that was outside her own value system. Joan reported interests in creative hobbies such as writing poetry, listening to music, and reading novels, which led me to suspect she would be a good candidate for hypnosis.

Hypnosis was an appropriate intervention, because all possible medical interventions had been explored in regard to her condition and no further medical treatment options were available at the time Joan presented for treatment.

OUTLINE OF TREATMENT

Sessions 1–3

The first session was used for information gathering and setting treatment agreements/boundaries. The second session was cancelled with less than 12 hours notice and could not be rescheduled (Joan advised she could not attend due to an increase in pain). The third session involved discussing various behavioural and cognitive techniques to reduce "comfort" eating. Assertive techniques for dealing with difficult situations with the insurance company and rehabilitation coordinator were discussed, and specific tasks and ways to help Joan engage at work were set as homework. She agreed to complete a mood and pain diary, rating pain levels between 1 and 5, and to do at least one thing per day that made her feel good (e.g., have a hot bath, buy and read a magazine, etc.) to help build self-esteem.

Session 4

In the fourth session hypnosis was introduced, as an extension of relaxation techniques that she could use to better manage her current pain levels. The Stanford Scale was used to assess her hypnotisability, although it was judged she would benefit to at least some degree given her previous positive experience of relaxation techniques. Joan scored 5 on the scale, revealing high hypnotisability.

Joan was asked to focus on her breathing and start to feel herself letting go of any tension in her body, with each breath in. She was encouraged to breathe in "calm" and let out "tension" when exhaling. Once she had visibly relaxed her posture, eye fixation was used as an induction technique. Joan was asked to focus her eyes on a spot until her eyelids became so heavy she was not able to hold them open any longer. Suggestions regarding not blinking, watering, flickering eyes were given in conjunction with eye movements to enhance this process. She was then asked to imagine she was on a beach, lying in the warm sun, and a picture of the various sights and sounds, smells, sensation and feelings associated with this place was suggested. Some suggestions that were given by Joan in the briefing prior to hypnosis were used, others were left as possibilities for Joan to incorporate into her imagery if she wished. Further deepening was carried out by counting from 1 to 10 and using the idea of watching the waves flow up the shore and drawing back into the ocean with each count to deepen the feeling of peace and relaxation. It was emphasised that Joan would be aware that any external noises were a part of the natural environment and would not distract her from trance. She would find it easy to focus on my voice throughout.

Content of the session included ego-strengthening based on suggestions taken from Hartland (1971), visualising her pain as a hard rock, which she imagined turning to a liquid and flowing out of her body (this image was provided by Joan in the briefing prior to hypnosis), reinforcing self-confidence, assertiveness in difficult situations, self-empowerment, and tapping into her ability to control her pain. It was suggested she might do this without even being completely aware of how she did it, based on Ericksonian suggestions regarding the power of the subconscious mind. A post-hypnotic suggestion of being able to re-enter trance more easily and quickly and gaining more benefit from each session was given. Joan was brought out of hypnosis by counting back from 10 to 1, advised she would be fully awake, refreshed and alert and ready to continue with the remainder of her day with renewed vigour, a

positive attitude, confidence, calmness, and a feeling of relaxation.

On awakening, Joan reported that she felt extremely relaxed and had no pain throughout hypnosis and after hypnosis, although she had rated her pain to be 2 out of 5 when she arrived for the session.

Session 5

In session 5, Joan reported she was starting to enjoy her job again and had carried out her homework, with positive results. She was making decisions regarding her future, and how she would go about achieving her long-term goals. She had been able to reduce her medication as her pain management was better and her pain was "annoying" rather than "overwhelming." She reported an occasional "electric shock" type pain like a "lightning bolt" in her left leg. It was agreed in this session I would suggest that, after the first shock she would imagine it going out of her leg, through her foot, so that it could not rebound up and down her leg as she usually experienced. She would also then turn down the voltage so that each shock she experienced gradually became weaker and weaker. Hypnosis was induced using progressive muscle relaxation, guided by my suggestions. Joan was asked to imagine herself in a safe place that she had chosen; to be on the beach at night, with a cool and invigorating breeze as a deepening technique. Due to the ease with which she had gone into trance this session, she was asked to use ideomotor signalling to indicate when she had reached her safe place. She was given a few minutes to enjoy the feeling of relaxation without interruption from me, until she was ready to let the scene fade away and move on. Content of this session involved ego-strengthening, and focusing on goals Joan had set for herself. For example, emphasis was put on a positive attitude, having love for herself, confidence, enjoying her job, a sense of being in control and feeling happy with herself, which would also be infectious to others around her. Future projection was incorporated by suggesting Joan see herself in the future when she no longer had her current difficulties and to note how she was feeling, what she was doing, and to allow herself to feel confident that this day was approaching. Pain management suggestions were given as in the previous session, incorporating new suggestions regarding the pain in her leg as outlined above. Post-hypnotic suggestions and de-hypnotising was carried out as in the previous session. Following this experience, Joan reported an inability to recall pain management suggestions until prompted and her memory remained hazy. Her overall experience was positive and again her pain rating was 0 during and following hypnosis.

Session 6

Joan reported a significant improvement in her ability to feel in control of her pain levels and that she had been able to reduce Digesic medication from ten to a maximum of four per day. She noted her level of pain reached a maximum of 2 out of 5 instead of a maximum of 4 out of 5 as she had reported prior to hypnotic intervention. Joan advised that, although she still experienced occasional shocks in her leg, they were more like a "dull ache" than a "lightning bolt" and after the first ache she did not experience the rebound effect she had felt previously. This was because she was comfortable with the suggestion of letting it flow out through her foot and had been practising this technique at home along with general relaxation, visual imagery, pain management imagery, and positive affirmations. During this final session eye fixation was used as an induction followed by guided progressive muscle relaxation and deepening was invoked by asking Joan to imagine going down 20 steps (because climbing up stairs was difficult at times) to a place where she felt total calm, peace, and relaxation. I counted the steps, altering my tone of voice and pace of speech to coincide with her breathing rate to enhance deepening effect. I reinforced the same pain management suggestions and also added pain management suggestions by Young (1989). Her post-hypnotic suggestion was to find it easy and motivating to continue practising these techniques at home and to gain more benefit each time. De-hypnotising was carried out by counting from 20 to 1, with awakening suggestions as described previously. Following this session Joan reported feeling tired for a few minutes, as if she had had a good sleep. At the end of this session, Joan mentioned she had been sceptical regarding the benefit of hypnosis at first. However, she had found the effects "quite good" overall and advised she felt motivated to continue implementing techniques learnt within the sessions.

DISCUSSION

No follow-up after the last session was possible due to the short-term nature of the intervention (EAP counselling). However, I felt the intervention was successful and that hypnosis was a catalyst for positive change. The main reason for the effectiveness of hypnosis in this instance was the fact that Joan's own suggestions and goals were utilised as much as possible. I felt positive regarding the lasting effect of treatment due to Joan's demonstrated compliance and increased motivation gained as a result of experiencing the benefits of treatment. Joan had much insight and reported gains in many aspects of her

life at the end of treatment. She was particularly pleased with the reduction in medication and pain levels and felt she could continue to reduce this with her own efforts. It is important to note that before Joan started to practise techniques at home she was taught each technique within a hypnosis session and educated on the safest and optimum way to do so. Although suggestions for pain reduction were given, in all sessions Joan was instructed to leave a small and manageable residue of discomfort present so that she could continue to monitor her condition in a safe way in order to be able to identify if she required further medical input in the future. Joan was provided with reinforcement regarding her own abilities and her capacity to continue to make positive changes in the future. This was important to allow her to feel ownership of her achievements; recognise my role as minimal and facilitative; reduce any possibility of breeding a dependence; and promote independence throughout treatment.

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HYPNOSIS IN THE TREATMENT OF A BANK HOLD-UP VICTIM

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This report describes the use of hypnosis in the treatment of post-traumatic stress disorder, resulting from exposure to a bank hold-up. It illustrates the effectiveness of hypnosis in the management of a case which was proving resistant to treatment.

Russell had been receiving regular psychotherapy following his being the victim of an armed hold-up while a bank manager in 1998. His psychotherapist was planning to go on extended leave and asked for my assistance in monitoring this client. The most important aspect of Russell's description of the hold-up was that he thought he, or a member of his staff, could die, and he recalled vividly the horror of watching helplessly while a staff member was "crying and begging for her life." Russell's description of his perceptions of the events during the hold-up and his reactions to his perceptions were consistent with the DSM-IV diagnostic criteria of post-traumatic stress disorder (PTSD). Given that his therapist would be returning, I chose to try hypnosis as a short-term intervention that would not require development of a deep client/therapist relationship, but that would be effective enough to address the severe symptoms Russell reported.

CLIENT HISTORY

Education and Employment

Russell completed his HSC in the early 1970s and at the time of writing was attempting to reskill himself in anticipation of a career change. His employment history was stable and he served 27 years with an Australian bank, being appointed to the level of branch manager in 1990 after demonstrating high levels of skill in his work performance.

Psychosocial History

Russell reported an unremarkable childhood. He married in 1972 and had one son who currently lives in Melbourne. His wife had two children from her previous marriage and Russell accepts them as his own sons. Overall, Russell reported a stable psychosocial history.

Pre–Hold–up Medical/Psychological History

Russell reported an unremarkable pre–hold–up medical history apart from receiving treatment for high blood pressure from his GP in 1996 and minor nasal surgery. He reported a one–month incident of work–related stress in 1997 for which he had time off work and received counselling with a local psychologist. He reported that he recovered from this and was successfully managing his workload prior to the hold–up.

Post–Hold–up Medical/Psychological History

Following critical incident stress debriefing, Russell commenced psychotherapy. Treatment included a cognitive–behavioural approach to the reduction of traumatic anxiety and relaxation training. He also received education regarding the cause and course of post–traumatic stress disorder to facilitate his understanding of the symptoms he was experiencing. At the completion of this treatment, in September 1999, Russell was referred to me for hypnosis, due to the levels of remaining traumatic anxiety symptoms and his current therapist taking four months leave of absence.

Precipitating Incident and Sequelae

Russell informed me that in February 1998 he was working in his office at the bank when he heard angry noises coming from the customer service area. He assumed that there was an angry customer in the bank and went out to intervene. Russell reported that on entering the customer service area he was confronted with the image of two armed bandits "in mid-flight jumping over the customer service counter." They were wearing black pants and had something that looked like stocking material covering their faces. Russell recalled feeling as though the bandits were pointing their guns directly at him and thinking that he might be shot. He reported lying face down on the floor feeling afraid for himself and for his staff. He recalled that at one point he heard a staff member crying while she was trying to open a safe with a timer

delay and thinking he should do something to help her, but he found himself unable to move or speak, fearing for his own life. Once the bandits left he set off the alarm and assisted his staff and later the police in their investigations.

Russell reported that after the hold-up he attempted to return to his previous routines after having attended critical incident stress debriefings and undertaking counselling. He informed me that in July 1998 he was unable to continue working at his previous level due to the intensity and extent of the traumatic stress symptoms experienced and, under the direction of his GP, he took a leave of absence under compensation leave. At the completion of psychotherapy he attempted a graduated return to work under the direction of a rehabilitation provider, but was unable to maintain his performance. Russell is currently taking the advice of his rehabilitation adviser to re-train himself into a new career.

Russell reported an exacerbation of symptoms in May and June 1999, when he was informed the bandits had been apprehended and had in fact killed a person in an earlier hold-up. Being made aware that the robbers had killed someone caused a resurgence of traumatic anxiety and exacerbation of other PTSD symptoms.

Medications

At the time of the hypnosis treatment Russell was prescribed Tritace (for mild to moderate essential hypertension), Aurorix (for depressive syndromes) and Viagra (reduced penile erectility).

PRESENTING SYMPTOMS

Russell's present emotional status was measured using the following psychological measures:

Symptom Checklist – 90R: This is a 90-item self-report measure of nine major areas of psychological disturbance and three global measures of psychological distress. Respondents rate the extent to which each of the 90 symptoms has bothered them during the past seven days. This assessment revealed that Russell felt that his body was not functioning as well as it was prior to the exacerbation. He had experienced an increase in physical symptoms such as headaches, general pain, chest pain, nausea and bodily weakness. There were also indications that Russell continued to experience thoughts and impulses related to the hold-up as being out of his control. His responses suggested he

was feeling inadequate and inferior. He demonstrated poor self-concept and lack of ego strength with elevated levels of anxiety, especially around other people. He also reported psychomotor retardation, biological depressive symptoms, and loss of interest in things previously enjoyed. Russell also endorsed items demonstrating overt clinical signs of anxiety. He described himself as nervous, tense, frustrated, and prone to having panic attacks. He reported high levels of nervousness, shakiness, trembling, and feeling suddenly scared, feeling fearful, restless, and having frightening thoughts and images. Moreover, his responses to items measuring phobic anxiety indicated that Russell was avoiding direct contact with reminders of the hold-up. These included avoidance of social situations and feelings, and social withdrawal. His responses also indicated that he was experiencing elevated hostility, suspiciousness, and irritability, and blaming others (in particular the bank) for his symptoms.

Impact of Events Scale (IES): This scale is used to screen for symptoms of post-traumatic anxiety. The IES contains 15 questions about the effects of thoughts or memories of the traumatic event, in this case the bank hold-up. Russell scored in the severe range (49) on this scale, which is consistent with symptoms of post-traumatic anxiety. He reported the most severe symptoms being the intrusive thoughts about the hold-up, being reminded of the hold-up often, and significant avoidance of discussions or thoughts about the hold-up.

Neuropsychological Symptom Checklist (NSC): This questionnaire assesses the patient's health and health habits. The subject is asked to identify which symptoms currently apply to him or her. Russell endorsed symptoms on the NSC indicating that he had recently experienced blurred vision, problems with muscle twitching, tremors and shakiness and problems with dropping things, numbness and tingling skin, headaches, fainting spells, memory problems, slowed thinking and increased distractibility, along with poor concentration. In addition to these symptoms he reported problems with sadness, stress, tension, and excessive worry.

TREATMENT PLAN AND CLINICAL SESSIONS

Russell agreed to receive hypnosis while his psychotherapist was on leave, with the basic goal being an attempt to desensitise the hold-up images and bring him back to a sense of an integrated self over five sessions as follows:

1. Induction;

2. Creating a safe place;

3. Revisiting the hold-up and desensitising images;

4. Transforming the trauma; and

5. Re-integration of experience with larger self.

Session 1: Induction

Guided progressive relaxation was used to bring Russell's body sensations into his awareness. He was encouraged to focus on his actual experience at that moment in time. Hypnotic induction was through the Spiegel Eye Roll procedure, and he scored as highly hypnotisable on this. After exiting the trance he was informed that all later steps would take place in the hypnotic state. The hypnotic state was described as a state of calm alertness to all aspects of a person's inner reality: emotional, physical, mental and spiritual. A tape of the induction and positive affirmations was made and Russell was asked to practise self-hypnosis twice a day.

Session 2: Creating a Safe Place

In this session Russell was invited through guided imagery to create a safe place within himself and to define parts of himself that contain resources to help with the process of transformation. Suggestions were given to return to this place if anything became too frightening or overwhelming. Also, as in each session, Russell was reminded that he had full control over the entire process and that he could be dehypnotised at any time on his signal (the signal he chose was to put his hand up as though indicating "stop").

As Russell had practised the hypnosis as agreed for homework, induction was successful and rapid. He was dehypnotised by counting out and drawing his awareness back to the surroundings. He reported that he was able to "be in his safe place" and that "it had been very clear and real." He left the session calm and relaxed. He was given a tape of the session to listen to once per day for the following week.

Session 3: Revisiting the Hold-up and Desensitising Images

Russell arrived at the session agitated and worried. He was aware that we would be working on desensitising hold-up images and had slept only three hours the night before in distressed anticipation. Therefore the first 30 minutes of the session was spent in creating safety and reinforcing that strength and

control were available to him. Toward the latter part of the 30 minutes it appeared that the desensitisation might need to be delayed while further work on safety and self-soothing was developed. However, Russell then settled and insisted that we commence desensitisation.

Hypnosis was induced using the eye roll technique. He now used the eye roll to induce self-hypnosis and was comfortable with the procedure. He was returned into the hold-up situation, establishing place and time by asking him to describe details related to the hold-up to bring him closer to the event. He was asked questions relating to sight, smell, touch, feel, hearing, and taste about his experience.

The events of the hold-up were reviewed again and again under hypnosis for about another 40 minutes until Russell reported a distress level of 2/10 when recalling the events. Throughout the procedure the level of safety was confirmed. There was no abreaction, although strong emotions of fear and some physical movements occurred early in the desensitisation for a brief period of time. He was reminded that it was safe to re-experience what he may have thought was not safe to experience the first time as he had developed resources and understanding since the hold-up to help him re-experience the trauma in a safe way.

Dehypnotising was very gradual with 10 minutes taken for recreating the safe place and some ego strengthening. Post-hypnotic suggestions focused on releasing fear and living safely. Homework for the following week was to practise self-hypnosis twice a day using the safe place and positive affirmations during induction.

Session 4: Transforming the Trauma

In this session metaphors and reframing techniques were used after Russell was induced into trance. For example, he was directed to bring his current coping resources to the self in the hold-up situation and to call forth these resources to transfer the "safety and strength" aspect of the experience to the memory. Russell was asked to re-enter the situation with the perspective of current day life. He was directed to see the situation and his reaction to the hold-up from this new perspective. Forgiveness of self for being unable to help his staff and forgiveness of the bank were also included here. Forgiveness was not forced, but presented as optional. Discharge of responsibility for events which he could not be logically responsible for was addressed, as this is often

an important factor in recovering an integrated sense of self.

An hypnotic metaphor for reframing adapted from Hammond (1990, p. 167) was incorporated, focusing on specific events during the hold-up. For example, Russell's memory of the teller sobbing was reframed as an emotional release for coping rather than uncontrollable fear.

Rational-emotive suggestions (Hammond, 1990, pp. 168-170) followed and dehypnotising was achieved through counting back.

Russell reported that while he was not yet ready to forgive the bank or the bandit for the hold-up, he had been able to forgive himself and reframe the main events in the hold-up. Homework was to continue self-hypnosis and ego-strengthening affirmations over the following week.

Session 5: Reintegration of Experience With Larger Self

The aim of session 5 was to reinforce Russell's shift in understanding of his experience, and to move on to re-integrating this newly understood experience into the larger framework of the self. After induction with the eye roll technique the following questions were asked:

1. What did you learn from this experience that you could not have learned any other way?
2. Can you bring this learning to past situations where you reacted with fear/shock/trauma and now insert this learning into that situation?
3. Feel how it shifts your experience/understanding of that situation. How can you visualise acting on this learning in future stressful situations?

Russell's responses indicated that he had developed an ability to deal with the full emotional and cognitive effects associated with the hold-up. He was now better able to recognise and manage panic and fear. He reported under hypnosis that he could now draw forth new perspectives on the hold-up and release the past. He described feeling as though he now has a new set of armour and was able to visualise himself walking into a bank, standing in line, and making a deposit or withdrawal without panic.

Russell was dehypnotised and the overall treatment reviewed. He agreed to continue self-hypnosis as required.

One-month Review and Discussion

Russell was seen one month after hypnosis had ceased. He reported ongoing problems with depressed mood and problems with memory, concentration,

and elevated anxiety. He informed me that his reduced attention, concentration and memory were continuing to make difficult his ability to engage in employment. At this review it appeared that Russell was at increased risk of never being able to work in a position commensurate with his bank manager position prior to the hold–up.

While hypnosis had been effective in assisting him manage his symptoms and in processing the trauma during treatment, once treatment ceased his recovery also ceased, suggesting that Russell would require ongoing treatment for his condition. He required ongoing treatment weekly or fortnightly for a further two months before he could maintain reduction of symptoms to an acceptable level. Even then he remained at reduced likelihood of being able to easily manage high levels of stress required in a position such as branch manager of a bank. Furthermore, the physiological effects of trauma on attention, concentration, and memory reduce his ability to retrain effectively while engaged in employment. Based on information available at 3-months post–hypnosis, it was my opinion that Russell was psychologically unfit to return to work for the bank and that he would remain psychologically unfit to return in the future. Indeed Russell was at increased risk of never being able to work directly with the public and money due to his feelings of compromised safety.

Overall, hypnosis did not "cure" the PTSD in five sessions, but I believe the sessions took him to a much fuller understanding of himself and the nature of his symptoms and what would be necessary for his recovery.

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The Best of Both Worlds: Combining Traditional and Ericksonian Hypnosis

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Although Milton Erickson used direct suggestions, popular thinking separates traditional from Ericksonian hypnosis by attributing the use of direct suggestion to traditional hypnotists and indirect suggestion to Ericksonians. Furthermore, many Ericksonians state indirection is superior, a theoretical belief contrary to recent research indicating they are equally effective. This paper presents clinical examples of direct and indirect (plus other aspects of Ericksonian hypnotherapy) according to the needs of clients. A combination approach may create initial confusion, but it may also facilitate a greater cure for more clients. It also returns us to Erickson's respect for scientific inquiry, his stress on the uniqueness of the individual and his use of many varied methods.

I will be looking at the theme of my paper, the integration of traditional and Ericksonian hypnosis, from two perspectives: (a) my personal experiences as a patient and practitioner of each method of hypnotherapy, and (b) the misconceptions that have evolved in each school of thought about the other, disregarding the results of research and clinical experience.

In addition, I will stress the value of accepting uncertainty and diversity, rather than looking for absolutes — that is, combining techniques rather than insisting that one method of hypnosis is better than the other. As mentioned, my interest in this topic stems from my personal experience. After years of practice as a psychoanalytic psychotherapist, I began to study hypnotherapy. First I integrated traditional hypnosis into my analytic work and then I combined Ericksonian hypnosis with traditional. In order to learn each hypnotic method I had to accomplish similar tasks: (a) learn new concepts and techniques and blend them with the old ones, and (b) deal with conflicts in colleagues and myself about the synthesis I was attempting, particularly when

colleagues misunderstood a method different from theirs and insisted theirs was better. (This included analysts declaring hypnosis is useless, and traditional and Ericksonian hypnotists each declaring the superiority of their technique.)

The conflict is diminishing. In July 1992, the Ericksonian Society and the International Society of Hypnosis scheduled contiguous conferences in Jerusalem to enhance communication. Colleagues in organisations of both traditional and Ericksonian hypnosis where I trained and on whose boards I serve acknowledged each other's value. Still, I feel, miscommunication and misperception continue. This creates an unfortunate situation. We have struggled with the larger therapeutic community to accept hypnosis. Now we struggle with each other rather than collaborate to our mutual benefit.

ERICKSONIAN VERSUS TRADITIONAL HYPNOSIS

I have heard Ericksonians call traditional hypnotists simplistic. I have heard traditional hypnotists call Ericksonians roundabout. Some Ericksonians think all traditional hypnotists are authoritarian. Some traditional hypnotists think Ericksonians never read research. The most interesting misunderstanding I heard came from a woman trained in Ericksonian hypnosis who wondered if her background would make a traditional hypnosis conference too irrelevant and conflictual for her. I assured her this was not the case and she later reported she had benefited from attending.

The conflict shows up in the literature. Weitzenhoeffer presented myths he feels leading Ericksonians hold about traditional hypnosis. Bloom (1991) and Kessler (1992) disagreed over what constitutes basic Ericksonian beliefs, but agreed we must communicate and collaborate to expand our knowledge and effectiveness.

As part of enhanced communication, we need to consider the differences between the two approaches. The answer is unclear, I feel.

Traditional hypnotists tend to be more directive and more research-oriented than Ericksonians. Yet they can be as permissive as Ericksonians, and some Ericksonians are very interested in research.

Traditional hypnotists stress suggestibility in accounting for the power of a hypnotic suggestion. Ericksonians stress the wisdom of the unconscious mind. The Ericksonians' methods include utilisation, word play, etc., not included in the traditional hypnotist's training. And the distinction I will emphasise later: The traditional hypnotist uses direct suggestion and the Ericksonian uses

indirect (even though Milton Erickson was a master of the direct suggestion).

In practice, however, these distinctions blur. I have heard Ericksonians give direct suggestions and traditional hypnotists tell stories and pace and lead their subjects, plus many more deviations from theory on both sides. Although my ideas may be new for some people, many others are already integrating methods, as Bloom discusses in his article (1994). Nonetheless, some persons may not be as comfortable or conscious of the possibilities. Since therapist comfort with technique is an important factor in therapeutic success, I feel it is important to encourage this integration.

Even more important is to remember that the state of consciousness we call hypnosis appears to be identical whether produced by an Ericksonian or traditional hypnotist. If indeed there is any difference in the phenomenological experience according to the techniques used, this should be explored in research, as Kessler (1992) points out.

DIRECT AND INDIRECT SUGGESTION

For the remainder of this paper I will focus on the issue mentioned above: The traditional hypnotist uses direct suggestion and the Ericksonian uses indirect, and, according to the Ericksonian, indirect suggestion is superior. I will define the two types of suggestions according to descriptions by Matthews, Bennett, Bean, and Gallagher (1985). The direct suggestion gives a clear, direct request for a certain response. Its purpose is obvious. The indirect suggestion is ambiguous, giving the client latitude, and allowing a wider range of interpretations.

As suggested earlier, Ericksonians sometimes use direct suggestion — including Milton Erickson. However, most classes and conferences of Ericksonian hypnosis I have attended emphasised indirection. The writings of several Ericksonian authors reflect this emphasis. Zeig (1985) says: "The main tool of the Ericksonian method is psychological level (indirect) communication." Lankton and Lankton (1983) state: "An Ericksonian therapist strives to be artfully indirect in all suggestions and interventions." Erickson and Rossi (1979) state the effectiveness of direct suggestion is limited. It gives the impression that change comes from the therapist not the client. Although it can effect an alteration in the client's behaviour it is a temporary, symptomatic cure, that ". . . does not entail that re-association and re-organisation of ideas, understandings and memories within the individual that are so essential for the

actual cure." They state that, for example, anaesthesia of the hand achieved by direct suggestion is a "pseudo anaesthesia" and "a simple superficial response" if the subject has not gone through those difficult inner processes via the indirect suggestion.

I disagree that anaesthesia of the hand is "superficial" or "pseudo" because it is produced by direct suggestion. Anaesthesia is a powerful phenomenon no matter how it is achieved. We must remember that the statements comparing the effectiveness of the two methods are theoretical, unverified by research. They are speculations, not fact. My own speculation is that direct suggestion can just as effectively stimulate a subject's healing potential, encourage re-association and re-organisation and lead to as full a cure as indirect methods. The cure might be especially powerful if we combine direct suggestions with various Ericksonian concepts such as utilisation, unconscious healing capacities, etc. along with indirect suggestions, thus having the best of both worlds.

Although we possess some understandings about the healing process, such as the value of the therapist–patient relationship and of the belief in the method, uncertainty remains about how healing occurs. It is important to speculate about psychotherapy and it is also important to separate speculation from research. Until research can tell us the relative efficacy of direct and indirect suggestions (as well as other important matters) I believe we should be less definitive about the workings of psychotherapy and hypnosis and more open to diversity.

Milton Erickson, after all, advocated diversity. Yet some of his followers, plus Erickson himself in the book he co-authored with Rossi (1979), stress indirect suggestion. Why? A fear of diversity, even in Erickson? An ambivalence about the power of directness?

Whatever the reason, it is important to evaluate the theoretical statements made above. In the following section I will summarise two reviews of the existing research literature, one by Hammond (1990) and the other by Lynn, Neufeld, and Mare (1993), comparing the efficacy of direct and indirect suggestions. I will then present criteria several clinicians suggest for using either technique, followed by my clinical examples and discussion.

RESEARCH ON DIRECT VERSUS INDIRECT SUGGESTIONS

Hammond looked at 21 research studies comparing the two methods, and Lynn et al. reviewed 29 studies. Both writers report that Barber's (1977)

experiment showing superior results with indirect suggestions for dental pain was not replicated in subsequent research. Both cite studies refuting the hypothesis that indirection reduces resistance, particularly one study indicating that two-level communication and interspersal of suggestion in a confusional dual induction was no more effective than a traditional induction and even tended to decrease responsiveness.

Hammond reports findings that subjects were heterogeneous in response to suggestions: that is, some were more responsive to direct, others more responsive to indirect, but most responded equally well to either.

Lynn says measures of subjective response to either type of suggestion were inconsistent. Some studies indicated direct suggestion produced greater subjective involvement, involuntariness, and diminished resistance, but others showed no difference in involuntariness or subjective involvement between the two suggestions. There was no indication that hypnotisability level and suggestion wording interact.

Both Hammond and Lynn et al. agree that although individual studies indicated one or the other method was more effective, the best controlled studies and the overall results found no advantage to indirection. Lynn et al. say that differences between suggestions seemed either non-existent or trivial. However, they recommend further research, before fully closing the case, since few well-controlled studies were conducted.

CRITERIA FOR DIRECT AND INDIRECT SUGGESTION

The results of research both clarify and confuse. If both methods are equivalent, it may not matter which one we use. Yet there may be times when one technique is better than another. Knowing those times is unclear, as different writers state different criteria.

Hammond (1990) says he uses direct suggestions with motivated, non-resistant, hypnotically talented subjects in a deep trance who state their preference for a direct approach. However, except for subject preference I feel these criteria are equally valid for indirection.

Kay Thompson, at a conference of the New York Milton H. Erickson Society, April, 1991, said she uses direct suggestion when a person needs: permission or authority to do something, a sense of control from the therapist, and a belief that something is happening. In contrast to Erickson and Rossi, she feels direct rather than indirect suggestions are best for pain control and medical procedures.

Yapko (1983) says direct suggestions can allow clients to feel more directly and consciously involved in the therapeutic process. Indirection will call upon the wisdom of the unconscious mind but also may confuse the client who may misunderstand the therapist's purposes and feel marginally involved in therapeutic change. I will illustrate these ideas in the following section.

INTEGRATING METHODS: A GENERAL PERSPECTIVE

In this section I will discuss my experience integrating traditional and Ericksonian hypnosis. At first, I will emphasise direct suggestion, and not include those times I found indirection highly effective.

When I first started training in Ericksonian hypnosis I found it so different from traditional approaches that in order to learn I temporarily stopped all use of traditional hypnosis. Only until I felt fairly solid with Ericksonian thinking did I start to integrate methods. In addition to utilisation, pacing and leading, etc., I began to use both methods of suggestion, interspersing direct suggestions with stories and metaphors. When a client wanted to stop smoking, for example, I told him to stop smoking, and suggested he see himself dropping a cigarette on the ground and crushing it with his heel. I then told a story about a stream that became polluted with debris, until a little boy came along and cleaned up the environment so that the stream flowed clear and easy and the boy stood on the bank and breathed in the fresh clean air. Then, I added: "You are now a non-smoker, and the need and the desire for smoking will simply wither away."

Usually I combine direct and indirect suggestions in each hypnotic session, as illustrated above. I will occasionally use only one form, as I will describe later. When I first began to combine suggestions I did not consciously consider criteria. I worked intuitively, choosing suggestions as they occurred to me at the moment (trusting my unconscious) and drawing upon my training in Ericksonian and traditional hypnosis and my experiences in personal hypnotherapy. Only later, when colleagues questioned me about criteria, did I consider them. Sometimes my choices fit with others' theory, though other times they did not.

One criterion I often use is ease. I enjoy creating stories and metaphors. This was one reason for my attraction to Ericksonian hypnosis. However, I usually find them harder to think of than direct suggestions. If for any reason I feel uncreative (whether this stems from factors in my client or in myself) I only give direct suggestions. At first I felt guilty doing so, even though my

hypnotic work was usually successful, believing if it was that easy I must be doing poor work. It was a relief to read the research literature and find that the simple direct suggestion is as effective as the elegant, creative metaphor or story.

It was also helpful to find that some people may respond better to one type of suggestion than to another. Though at first I combined the two methods of suggestion unconsciously in response to my own experiences, I later did so intentionally as a shotgun approach, like Erickson used, to cover all bases.

Usually, when I first hypnotise a client, I use a traditional induction rather than a conversational approach. (I instruct the client to imagine a safe place, guide him or her in progressive relaxation and concentration on breathing, and deepen the trance by counting from 10 to 1.) I feel direct suggestion is helpful for a first time experience because it provides a sense of structure and a feeling that something is being done, as Thompson said regarding direct suggestion. I usually switch to a conversational induction for the client's second trance, explaining there are several ways to experience hypnosis. After that I alternate between methods, according to my inclination that day, as I generally find them equally effective.

With one client, however, this was not the case. I had hypnotised him frequently using both methods of induction. In this session he stated his determination to get to the bottom of his problems and really change. I started a conversational induction and indirect suggestions that I felt were responsive to my client's dynamics and creative in my choice of words. My client stopped me and said he was in a light trance. He wanted me to take him by the hand and guide him very deep so that he could really solve his problems. I switched to a traditional induction and direct suggestions and he reported a much more satisfying trance.

This example illustrates the client's need for structure and for a sense that the therapist is taking charge and doing something, as Thompson discussed. I find this need surfaces often when clients with problems including anxiety, depression, assertiveness, smoking cessation, etc. ask for something "stronger" than the indirect suggestions I have just used. I then switch to direct suggestions only and the client usually finds this productive. It is possible that my client's deeper trance resulted from fractionation, not the different method. It is also possible that his and other clients' satisfactory results stemmed from my responsiveness to them, not from my direct suggestion. As mentioned earlier, we know relatively little about how hypnotic suggestions work. Is success due to the wording? The length? The therapeutic relationship? The client's

motivation? It is important to note one client who felt my indirect hypnotic work was weak, did, nonetheless, achieve her goal to stop smoking. Again, since hypnotherapists don't know for sure what works, be open to all possibilities. Here is another clinical example where the client equated direct suggestion with effectiveness.

I had used trance often with this client and she had responded well to all sorts of techniques. One session she wanted to write the hypnosis script herself and record it during the session in her voice. At her request I explained the various types of suggestions, but she said she would only use direct suggestion, not metaphor, because she said, "I want to be sure this works."

Another client wanted trance to motivate her to clean her apartment. I began a story about a little girl who was washing dishes and looking at rainbows in the soapsuds when the client said, "Tell me to wash the dishes." I did. She said, "Tell me to file my papers." I did that too. She then said, "Tell me to go to the gym." Again I followed her instructions and she later reported the trance had been a success.

In line with the research, which states that many subjects respond well to both types of suggestion, so did this client. In another trance I compared the energy of her anger to the waters of the river which can either overflow the banks creating havoc or nurture the land, growing flowers and food. She later said the trance helped her gain perspective and control of her rage.

Perhaps the second indirect suggestion was more effective than the first because it was better formulated. Perhaps a direct suggestion would have also worked in the second example. We cannot know, but it is good to have both methods to call upon.

One of the most valuable uses of direct suggestion for me has been Hartland's ego-strengthening techniques (included in Hammond, 1990). This is a series of direct statements that the client will feel strong, relaxed, confident, optimistic, etc. I experienced it in my therapy and use it extensively in my work, almost always successfully. Perhaps it is effective because people need permission to be strong, referring again to Thompson's statements. Perhaps my personal success with it is conveyed to my clients.

One client reacted adversely to Hartland's suggestions, however. The positive statements distressed her as a reminder of all she was not. Indirect suggestions might have worked for her, but unfortunately I had not begun my Ericksonian training and I stopped using hypnosis with her. (She remained with me and made considerable improvement, but without the benefit of hypnosis.) In retrospect, I wonder if the prooblem was not the direct

suggestions, but my neglect of her fear she could never change. Perhaps if I had addressed this, rather than impose optimism on her, a hypnotic intervention either direct or indirect might have worked.

Another client, struggling with alientation from her family and uncertainty about her identity, found indirection unhelpful. I created a long story about a young swan ostracised from her family, listening to the wise owl calling "Who? Who?" and finding meaning in her life. My client, in illustration of Yapko's comments, said she felt restless during hypnosis. She didn't understand the purpose of my story and wanted me to say the words she wished were inside her head. The next hypnotic session I used only direct suggestions and she reported this direct trance was helpful.

As indicated in my discussion of these examples, we don't always know why a method does or doesn't work. I used direct suggestions with a client and helped her stop smoking. I thought to myself: she is retarded; she needed a direct, authoritarian approach. But I realise that I spoke in hindsight at the end of a successful treatment. Had I tried it, indirection might have been equally effective.

A study by Matthews and Langdell (1989) presents another illustration of the importance of reconsidering theory in light of both clinical findings and research data. The authors provided hypnotic subjects with three sessions that included multiple embedded metaphors. They found that the sessions were effective — but that they were most effective when the clients could later remember the metaphors they heard in trance.

This finding contradicts Ericksons's thinking (Erickson & Rossi, 1979) that hypnotic suggestions should remain unconscious in order to be most effective. Instead, Matthews and Langdell hypothesised, in thoughts similar to Thompson's ideas about the value of direct suggestion, conscious awareness may give clients a sense of control over the therapy process and thus enhance change.

Here again, research questions theory. However, as the authors say, experimental results do not repudiate Erickson, but rather, free us from the tyranny of technique. In addition, I believe, they support Erickson as a scientist who would advocate careful examination of hypotheses. They remind us that the more we question our assumptions the greater flexibility we can achieve to think freely and to work effectively.

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BOOK REVIEWS

Scripts and Strategies in Hypnotherapy

Roger P. Allen

Camarthen: Crown House Publishing. 1997. x + 180.
$69.00 + postage and handling; hardcover.

Roger Allen has collected a potpourri of scripts which he recommends for the beginning hypnotherapist. The collection provides a variety of hypnotic techniques and scripts designed to assist people who present with a variety of problems. Unfortunately, the organisation and structure of the book leaves the reader in a state of confusion. My feeling was that someone at the printers must have dropped the manuscript just before it went to press and just bundled the pages together ad hoc! In addition, the text format was very repetitive and there was not enough light and shade between fonts and bold to help the reader to be speedily resourceful in collecting information.

The book begins well with an introduction which owns the author's eclecticism and practical focus. He has drawn heavily on more indirect methods such as those derived from neurolinguistic programming. The recommendation is that the script be adapted, not adopted, so that the therapist tailors the content to suit the client's specific problem in session. Pre-recorded audiotapes are to be used as adjuncts and follow-up to individualised practical sessions and not as "processed cheese for an eager guinea-pig looking for the hypnotic magic wand."

There follow six recommended inductions and four deepeners. I was surprised to note that the latter are recommended as not necessarily used, with no consideration of the hypnotisability differences between clients.

The rest of the book is the scripts and they seem to be randomly arranged with no real system for the reader to easily follow. The author adds to the confusion by mixing hypnotic techniques with topic scripts. For instance, "Anchors" is followed by "Nail Biting," "Sexual Problems (Impotence and Inorgasmia)," "Taking Responsibility," "Pleasure Returned" (which is about helping premature ejaculation), and "Pain Management"!

I had to reorganise the order by my system of separating techniques from topics. Techniques include "Anchors," "Parts Therapy," "Past Life Recall" (surely not recommended for the beginning practitioner), "Amnesia," and "Coping with Abreaction."

Topics would be best ordered by the intent (e.g., "HypnoStress" includes "Pain," "Anger," and "Depression"), "HypnoSuccess" ("Pass your Driving Test," "Sports Performance"), "HypnoHabits" ("Stop Smoking," "Lose Weight").

The "HypnoHabits" topics certainly offer the beginning hypnotherapist substantial models for hypnotic application, since these topics are most commonly those which present for the new practitioner. These may be recommended as confidence builders for both beginning therapist and client.

The main caution that I make in assessing this book is that there are very few examples of real-life cases where the scripts were used. The metaphor of "making model airplanes" which are then individualised as the therapist matures, worries me. How many clients are necessary as models before the real substance of the hypnotherapy matures?

I recommend that readers who are beginning in hypnotherapy use the scripts with supervision from an experienced practitioner. The latter could be frustrated by the collection due to its lack of organisation.

JANET HALL, Psychologist, Melbourne

Hypnosis: A Comprehensive Guide

Tad James with Lorraine Flores and Jack Schober.

Carmarthen: Crown House Publishing. 2000. x + 231.
$83.00 + postage and handling; hard cover.

Comprehensive guides are usually very long and detailed. James has compressed the contemporary approach to hypnosis in what amounts to a review. Incidentally, there are reviews on the publisher website, two of which are very thorough examinations of this book (www.crownhouse.co.uk).

For the experienced or novice practitioner, this guide is a useful professional development checklist. Modern developments in hypnotic strategies, especially from Erickson and NLP, are delineated from integrated into traditional approaches. The two purposes are to "lead others to rich benefits of trance … On the other hand, we are learning how to be very good hypnotic subjects,

so that we can access those benefits … People who are in rapport with their Unconscious Minds are also in control of their destiny'' (p. 7).

Thus, we are swept through the history of hypnosis, trance, Milton model patterns, history taking, suggestibility tests, and then into Ericksonian, Estobrooks, and Elman methods with specific chapters on deepening techniques and developing induction styles. Practical lists and techniques with case studies, even the use of the Pendulum, are sprinkled through the book, to excellent effect.

James is personally committed to a combination of time line (his own approach), neuro-linguistic programming and hypnosis. He believes that the last named is a generalised way of confirming specific therapeutic aspects for the unconscious mind to act on. He often uses all these methodologies in one session.

Interestingly, he is very cautious in his use of hypnosis, stipulating five instances in which he believes it is contraindicated. These are with clients "dangerous to themselves or others"; "if the client is dealing with highly repressed or traumatic issues" then refer on. Here he implies that hypnosis is generally used by a variety of helpers; in dealing with cancer it is inappropriate to offer a cure. Next, when a client suffers from a psychiatric or neurological disorder, he advises to obtain a medical referral and back up. Finally, he highlights: "You should only hypnotise a member of the opposite sex when there is a reliable witness present. Erickson, for example, would not hypnotise a woman unless his wife was present." All of the above seem more like procedures to ensure sound practice, correct referral, and prevention of misunderstandings and/or misuse of hypnosis.

Finally, the book provides a bibliography covering the origins of modern hypnosis. A worthy addition to anyone's library.

JOHN W. REDMAN, Psychologist, Morwell, Victoria

REFERENCE

James, T., and Woodsmall, W. (1988). *Time line therapy and the basis of personality*. Cupertino: Meta Publication.

BOOKS AVAILABLE FOR REVIEW

Full members of the Australian Society of Hypnosis interested in reviewing books should apply to the editor. Reviews are subject to editorial review prior to publication. Reviewers are required to return books to the Board of Education of the Society, for use as part of the Distance Education Programme.

Rubin Battino	*Guided Imagery and Other Approaches to Healing.* Carmarthen: Crown House Publishing, 2000.
George Gafner & Sonja Benson	*Handbook of Hypnotic Inductions.* New York: W. W. Norton & Co, 2000.
Moshe Lang & Peter McCallum	*The Answer Within.* Camberwell, Vic.: Australian Council for Educational Research, 2000.
Donald R. Liggett	*Sport Hypnosis.* Adelaide: Human Kinetics, 2000.
Marty Sapp	*Hypnosis, Dissociation, and Absorption.* Springfield, IL: Charles C. Thomas, 2000.
Anees A. Sheikh (Ed)	*Therapeutic Imagery Techniques.* Amityville, NY: Baywood Publishing Company Inc, 2002.

INFORMATION FOR AUTHORS

1. Contributions should conform to the style outlined in the *Publication Manual of the American Psychological Association* (3rd ed.; 1983), except that spelling should conform to *The Macquarie Dictionary*. Page references in the following notes are to the *Publication Manual*. The attention of authors is especially drawn to changes in the third edition (p. 13).

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